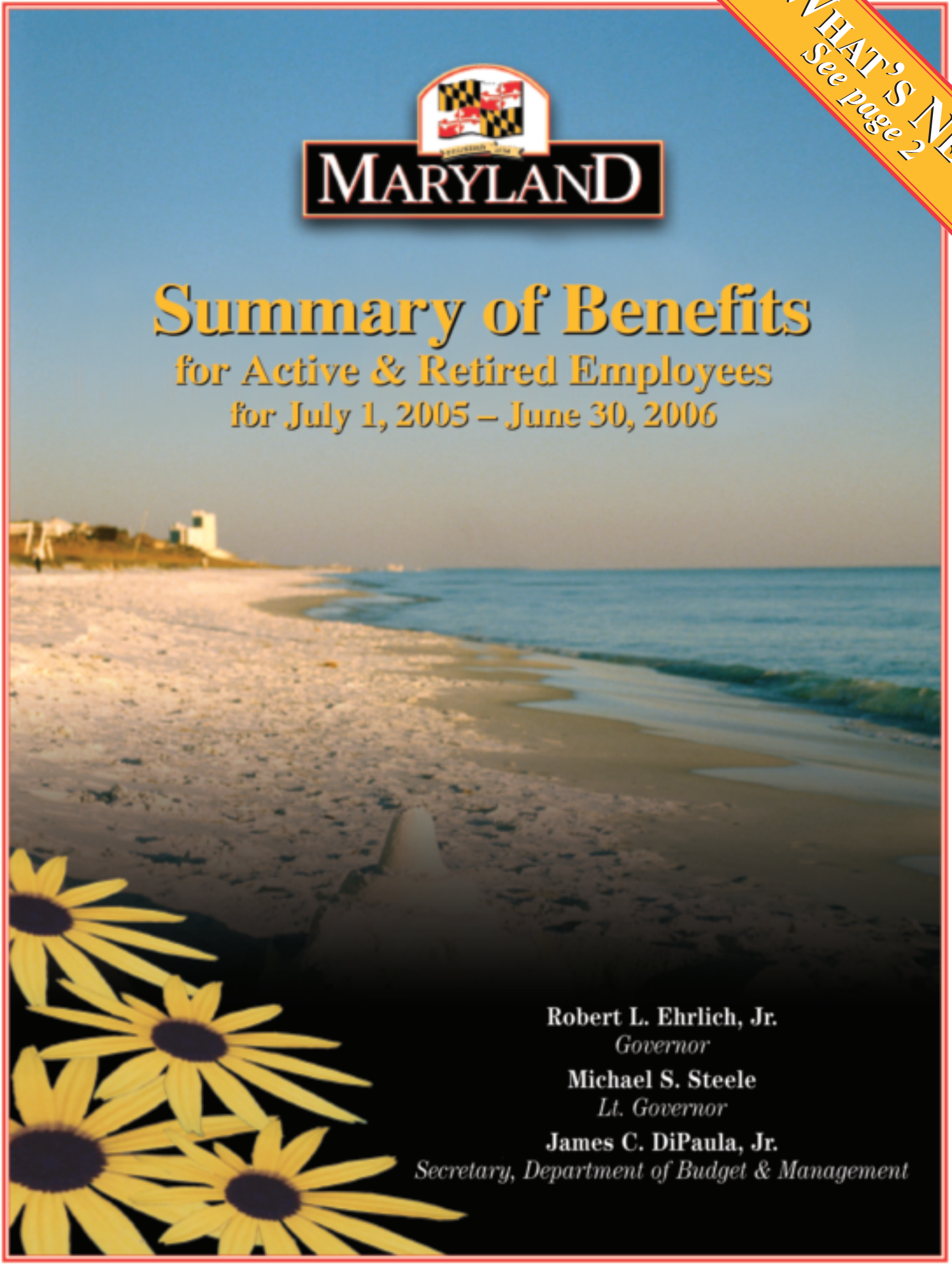
What's New
See page 2

MARYLAND

Summary of Benefits

for Active & Retired Employees

for July 1, 2005 – June 30, 2006



Robert L. Ehrlich, Jr.
Governor

Michael S. Steele
Lt. Governor

James C. DiPaula, Jr.
Secretary, Department of Budget & Management

For more information, visit our website: www.dbm.maryland.gov

NOTE: THE TERM LIFE INSURANCE PLAN IS WITH STANDARD INSURANCE COMPANY

Age of Employee	Bi-Weekly Employee Rate (per $10,000)	Monthly Employee Rate (per $10,000)	Age of Spouse	Bi-Weekly Spouse Rate (per $5,000)	Monthly Spouse Rate (per $5,000)
Under 20	.29	.58	Under 20	.31	.62
20 to 29	.29	.58	20 to 29	.31	.62
30 to 40	.35	.70	30 to 34	.34	.68
35 to 39	.46	.92	35 to 39	.42	.84
40 to 44	.72	1.43	40 to 44	.62	1.24
45 to 49	1.16	2.32	45 to 49	.96	1.92
50 to 54	1.88	3.75	50 to 54	1.44	2.87
55 to 59	3.24	6.48	55 to 59	2.23	4.45
60 to 64	4.68	9.36	60 to 64	3.41	6.82
65 to 69	6.99	13.98	65 to 69	4.96	9.92
70to 74	12.51	25.02	70 to 74	7.80	15.60
75 to 79	24.47	48.94	75 to 79	7.80	15.60
80 and older	24.47	48.94	80 and older	7.80	15.60
Dependent Child Coverage is .95 per $5,000 per month					

NOTE: THE AD&D PLAN IS WITH THE METROPOLITAN LIFE INSURANCE COMPANY

(Available only to Active Employees)

JULY 1, 2005 – JUNE 30, 2006 AD&D PLAN RATES

Plan Coverage Level	Employee Only Biweekly	Employee + Family Biweekly	Employee Only Monthly	Employee + Family Monthly
$100,000	$0.90	$1.65	$1.80	$3.30
$200,000	$1.80	$3.30	$3.60	$6.60
$300,000	$2.70	$4.95	$5.40	$9.90

THIS BOOK IS NOT A CONTRACT

This book is a summary of general benefits available to State of Maryland active employees and retirees and the procedures to be followed to secure such benefits. Wherever conflicts occur between the contents of this book and the contracts, rules, regulations, or laws governing the administration of the various programs, the terms set forth in the various program contracts, rules, regulations, or laws shall prevail. Space does not permit listing all limitations and exclusions that apply to each plan. Before using your benefits, call the plan for information.

NOTICE TO EMPLOYEES AND THEIR DEPENDENTS

The State Employee Health Benefits Program is covered by the Public Health Service Act (PHSA) and the provisions of the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA), which are included in the PHSA. The Program and the plans offered through it are not covered by ERISA. A detailed COBRA Notice to all employees and their dependents that explains COBRA rights and obligations is found in this book.

Summary of General Benefits
July 2005 – June 2006

Maryland State Employees/Retirees Health Benefits

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WHAT'S NEW STARTING JULY 2005

Prescription Drug Benefits for July 1, 2005 – June 30, 2006

There are several changes to your Prescription Drug Benefits starting on July 1, 2005. You may still continue to use your Caremark membership card.

The changes to your Prescription Drug Benefits include changes to the co-payments you pay for a prescription, drugs which will require Prior Authorization before your prescription can be covered, limitations on the amounts you can purchase per prescription for certain drugs and other changes listed below. A Voluntary Mail Order Plan will also be available to you and your family.

The list below provides a summary of your Prescription Drug Benefits changes:

New Co-payments for Each Prescription Fill/Refill:

- $5 Generic Drugs
- $15 Preferred Brand Name Drugs
- $25 Non-Preferred Brand Name Drugs

Your Annual Out-of-Pocket Maximum Co-payment Amounts: Once the total Out-of-Pocket co-payments reach $700 in the benefit year (July 1, 2005-June 30, 2006), you will not pay any further co-payments for the benefit year for covered drugs for all covered family members.

Your Supply per Prescription: For prescriptions written for less than 45 days, you will pay one co-payment. For prescriptions written for 45-90 days, you will pay 2 co-payments.

Drugs Requiring Prior Authorization: Certain drugs require Prior Authorization from Caremark for coverage. Your physician will need to submit medical documentation. Drugs requiring prior authorization include, but are not limited to: Growth Hormones, Retin-A for individuals aged 26 and older, Accutane, etc.

Limitation on Certain Drugs: For certain types of prescription drugs, there are limitations placed on the amount of covered quantities you may obtain for a certain period of time, called "Managed Drug Limitations", including, but not limited to: Viagra, Imitrex, Flovent, Flonase, and Zofran.

Step Therapy: For certain drug classifications, Step Therapy is a process for finding the best treatment while ensuring you are receiving the most appropriate drug therapy and helping to reduce your pharmacy costs. For certain classes of drugs covered under Step Therapy, you are required to use first-line alternative drugs to receive benefits coverage.

Voluntary Mail Order Plan: You may choose to obtain your prescriptions through a Voluntary Mail Order Plan with Caremark. You may have prescriptions refilled online through the Internet or by calling a toll-free telephone number under the Voluntary Mail Order Program. Please refer to the Prescription Drug Plan section for more details.

For further information, read the "Prescription Drug Plan" section of this Benefits Booklet and contact Caremark at their toll-free phone number and website shown below.

For More Information Contact Caremark at:

Caremark Prescription Plan Hotline:
1-800-345-9384

Caremark Website for State Members:
https://maryland.advancerx.com

On the Caremark website:
For Open Enrollment and new benefits questions, log in as a user Maryland@testsite.com password: password 1.

Open Enrollment Hotlines:
1-866-268-4459

Email your questions to: dbmbenefitshelp@dbm.state.md.us
(Available during Open Enrollment Only)

SUMMARY OF BENEFITS FOR JULY 2005-JUNE 2006

Medical Plans

- Two Preferred Provider Organizations (PPO) Plans
- Three Point-of Service (POS) Plans
- Three HMO Plans

New Prescription Plan Changes Effective July 1, 2005-June 30, 2006

- Prescription co-pays: $5 (Generic), $15 (Preferred Brand) and $25 (Non-Preferred Brand)
- Additional changes, including Drug Limitations, Days Supply, Voluntary Mail Order Plans, etc. Read the Prescription Drug Plan section of this Benefits Booklet for more information.

Dental Plans

- Three dental plan options: two Dental Health Maintenance Organizations (DHMO)
- One Preferred Provider Option (PPO) Plan
- No Point of Service Plan (POS) is offered
- No dental benefits are included in any medical plan

Mental Health/Substance Abuse Plan

- If you choose a PPO or POS medical plan, all of your mental health and substance abuse treatment will be coordinated by the Mental Health/Substance Plan (APS Healthcare).
- If you choose an HMO medical plan, your mental health/substance abuse treatment will be coordinated through your HMO.

Term Life Insurance

- Up to $50,000 in coverage without medical review. Up to $300,000 in coverage with medical review.
- Spouses and dependents are also eligible for coverage at half of the employee's coverage amount.
- Retirees who retired in 1995 or later can continue coverage if they were enrolled in Term Life as an active employee. Once a retiree terminates life insurance coverage, it cannot be reinstated.

Accidental Death and Dismemberment Insurance (Active Employees Only)

- Lump sum payment if you suffer dismemberment or death due to an accident.

Flexible Spending Accounts (Active Employees Only)

- Tax-free reimbursement accounts for eligible expenses for: medical care for employees and dependents; day care for eligible dependents.

Long Term Care

- Coverage for Nursing Home care, Adult Day care etc., for covered members with Activities of Daily Living (ADL)-certified disabilities.

Dependent Eligibility

The following documentation is required:

- Spouse (must provide Official Marriage certificate)
- As of January 1, 2005 in order for a dependent to be eligible for benefits, employees are required to fill out and sign the "State of Maryland Affidavit of Tax Status of Dependent Children." This applies if the dependent is a natural child, grandchild, adopted child, legal ward, stepchild, etc. A birth certificate must also be provided. This affidavit is available on the DBM website, www.dbm.maryland.gov. and then click on Employee Services.
- The Affidavit includes an excerpt from the State regulation (COMAR 17.04.13A(11) that governs eligibility of dependent children.
- You may add a dependent outside of the Open Enrollment period within 60 days of the qualifying event (marriage, birth, adoption, gaining eligibility).

OPEN ENROLLMENT INTERACTIVE VOICE RESPONSE (IVR) ENROLLMENT INSTRUCTIONS

During Open Enrollment, you must use the Interactive Voice Response (IVR) system to enroll, make changes to your benefits, and add or delete dependents.

- The IVR is an automated telephone enrollment system. You must call the IVR using a touch-tone telephone.
- The IVR will be available 24 hours a day, 7 days a week during Open Enrollment.
- For Open Enrollment, you will receive a personalized Benefit Statement. The Statement contains pre-printed information about you and your benefit coverage for Year 2005-2006. Please review the statement before making your telephone call. If you do not want to change your benefits enrollment and do not want to enroll in a flexible spending account for Plan Year 2005-2006, you will not need to call the IVR.

BEFORE YOU CALL, USE THIS CHECKLIST:

- ❑ Review your Benefits Booklet and Benefits Statement.
- ❑ Decide what changes and/or selections you want to make.
- ❑ Have your Benefit Statement and PIN Number next to the telephone.
- ❑ Decide what you want to contribute to a Flexible Spending Account (FSA) if you are enrolling in a FSA for the first time or wish to continue participating in a FSA. (Active employees only).
  1. Decide on the total amount you want deducted for July 2005 – June 2006: _____
  2. Calculate your per pay deduction _____

  (Note: Central Payroll employees will have 24 deductions. University employees who are 21-pay employees should contact their Agency Benefits Coordinator to determine number of deductions).

- ❑ Have the following information for each dependent you are adding or making changes to his/her information:
  1. Name
  2. Social Security Number
  3. Gender
  4. Relationship
  5. Date of Birth

Special Instructions for Adding or Deleting Dependents:

- **The IVR automated attendant will ask you to Speak or Spell your dependents name. Do not use the touch pad for numbers. You must speak both the numbers and names for them to be recorded. Please speak clearly. If you added or deleted a dependent, you may need to change the coverage level of your plans. If you added a dependent to your dependent file the system will not automatically add the dependent to your plans or change your coverage level. The automated attendant will ask you to say, "Yes" or "No" to add the dependent to your plans. It takes 48 hours for your dependent information to be added to your Summary Statement.**
- **If you add a dependent, you must supply your Agency Benefits Coordinator with the required documentation within 30 days of the date of your IVR System call. (See Required Documentation of Dependents section of this book). If you do not supply the Agency Benefits Coordinator with these documents by the deadline, your dependent is not eligible for coverage even if the dependent is still listed on your dependent file.**
- **If you add an ineligible dependent to your coverage or if you fail to remove an ineligible dependent, you will be required to pay the individual premium and the full State subsidy for the ineligible dependent for each month that the dependent remained enrolled.**

Now you are ready to call

- Call 410-669-3893 (Baltimore area) or 1-888-578-6434 (outside Baltimore area). If you use a teletype machine, call TTY: 410-333-5244. The IVR is available 24 hours a day, 7 days a week during Open Enrollment.

- If you are enrolling in benefits for the first time or re-enrolling after cancellation of benefits, a benefit package will have to be created for you. The automated IVR attendant will instruct you to press Option 8 to speak to an operator. An operator will only be available from 8:30 am to 4:30 pm Monday through Friday except for State holidays and emergency situations.

- The IVR automated attendant will guide you through the system for the following plans: Medical, Prescription Drug, Dental, Personal Accident and Dismemberment, Flexible Spending Account, and Life Insurance, and for adding and deleting dependents.

- After each and every selection you make, the IVR automated attendant will confirm what you have selected. You will then be able to confirm the selection or cancel it and make a different choice.

- If you need assistance using the IVR, you may contact your Agency Benefits Coordinator in your Personnel Office (for active employees) or call the Employee Benefits Division (for retirees) during business hours. The Employee Benefits Division has Customer Service Representatives available from 8:30 am to 4:30 pm Monday through Friday, except for State holidays and emergency situations.

- An updated Summary Statement of Benefits will be sent to you through your Agency Benefits Coordinator (for active employees) or mailed to your home address (for retirees) within 10 days after your IVR telephone call. The Summary Statement will list what benefits you have chosen for Plan Year 2005-2006 and confirm the date of your IVR telephone call. Review the Summary Statement carefully to confirm that the changes are correct. If the changes are not correct, call the IVR again to make the correct changes. No changes can be made after the Open Enrollment period ends.

As the IVR is available 24 hours a day seven days a week, during Open Enrollment, the best time to use it is during the non-peak hours of late evening to early morning.

Make your changes early. There is a large volume of calls the last few days of Open Enrollment. You have a greater chance of getting a busy signal during this period.

STATE OF MARYLAND BENEFIT PLAN CHOICES FOR JULY 1, 2005 – JUNE 30, 2006

The State of Maryland offers a wide range of health benefits. Please carefully review the following descriptions to choose the type of plan best suited to your needs. This information is only a general overview of available options. If you require specific information about coverage, limitations, exclusions, participating providers, or preauthorization requirements, you must contact the plans directly. Telephone numbers and websites are located on the back cover of this book. Each plan has service representatives that are dedicated to the State account and can assist you with any questions you have about the plan's coverage.

Cafeteria Plan (for Regular full-time and more than 50% part-time State employees only): A cafeteria plan is an employer-sponsored funding plan for certain health and welfare benefits, under Section 125 of the Internal Revenue Code, that offers the opportunity to choose among non-taxable benefits such as medical or dental coverage. If you choose to enroll in coverage for qualified benefits, the amount you pay for premiums is tax-free. It will not be included in your gross income for the plan year.

Regular State/Satellite Employees	**Contractual State Employees** Less than 50% Part-Time State Employees	**State Retirees**
Medical Plans All health plans include vision benefits. All mental health/substance abuse coverage for PPO and POS plans is managed by APS Healthcare, Inc. (APS). Mental health/substance abuse coverage for HMO plans is managed by the HMO.		
PPO Plans		
CareFirst Blue Cross Blue Shield PPO MLH-Eagle (MAMSI)	CareFirst Blue Cross Blue Shield PPO MLH-Eagle (MAMSI)	CareFirst Blue Cross Blue Shield PPO MLH-Eagle (MAMSI)
POS Plans		
CareFirst Blue Cross Blue Shield MPOS M.D. IPA Preferred Aetna QPOS	CareFirst Blue Cross Blue Shield MPOS M.D. IPA Preferred Aetna QPOS	CareFirst Blue Cross Blue Shield MPOS M.D. IPA Preferred Aetna QPOS
HMO Plans		
CareFirst Blue Cross Blue Shield BlueChoice Optimum Choice (MAMSI) Kaiser Permanente	CareFirst Blue Cross Blue Shield BlueChoice Optimum Choice (MAMSI) Kaiser Permanente	CareFirst Blue Cross Blue Shield BlueChoice Optimum Choice (MAMSI) Kaiser Permanente For retirees and their dependents who are Medicare eligible, all medical plans are supplemental to Medicare Parts A&B.
Prescription Plan		
Caremark	Caremark	Caremark
Dental Plans		
United Concordia DPPO United Concordia DHMO Dental Benefit Providers DHMO	United Concordia DPPO United Concordia DHMO Dental Benefit Providers DHMO	United Concordia DPPO United Concordia DHMO Dental Benefit Providers DHMO

Plan Choices continued on page 8

Regular State/Satellite Employees	Contractual State Employees Less than 50% Part-Time State Employees	State Retirees
Term Life Insurance Plan		
The Standard	The Standard	The Standard
Effective January 1, 1995, only retirees who are enrolled in life insurance as an active employee at the time of retirement may continue life insurance coverage. See Life Insurance section for more details.		
Personal Accidental Death and Dismemberment		
Metropolitan Life Insurance Company	Metropolitan Life Insurance Company	(not available)
Flexible Spending Accounts – Health Care Spending Accounts and Daycare Spending Accounts		
Administrator to be determined	(not available)	(not available)
Long Term Care Plan		
Unum Life Insurance Company	(not available)	Unum Life Insurance Company (if converted)
A separate enrollment sheet must be completed and mailed to Unum. Upon retirement or leaving State service, employees who are enrolled in long term care insurance must contact Unum to complete a conversion form within 90 days of the end of employment.		

WHO IS ELIGIBLE FOR HEALTH BENEFITS?

FULL-TIME ACTIVE EMPLOYEES

- Employees who are regularly paid salary or wages through an official State payroll center, including but not limited to: Central Payroll Bureau, Mass Transit Administration, and University of Maryland, including graduate assistants, and the University's Far East and European Divisions.
- Elected State Officials
- Registers of Wills and employees of the office of Registers of Wills
- Clerks of the Court and employees of the offices of Clerks of the Court
- State Board or Commission members who are regularly paid salary or wages and work at least 50% of the work week
- Employees of political subdivisions which participate in the State's health benefits program with the approval of the governing body
- Employees of agencies, commissions, or organizations permitted to participate in the State's health benefits program by law

CONTRACTUAL AND PART-TIME EMPLOYEES

Contractual and part-time State employees are eligible to enroll in the same benefits as full-time State employees, with the exception of the Flexible Spending Accounts and Long Term Care. Part-time employees who work less than 50% of a regular workweek and contractual employees must pay the entire cost of the plans, including the State subsidy. Contractual and part-time employees must follow the same participation rules as full-time employees, with the exception of the following:

- The effective date of coverage cannot be changed once the Enrollment Worksheet has been processed. (A letter must be attached with the Worksheet if the employee is requesting an effective date other than the current processing date.)
- Changes to coverage cannot be made at the time of a contract renewal.
- If you leave State service, notify the Employee Benefits Division in writing to receive your COBRA package.

Coupons and Payments: All contractual and part-time State employees will be mailed payment coupons, which must be included with their premium payments at the address given on your enrollment worksheet. Your benefits will be effective as of the date noted on your letter but no claims will be paid until the Employee Benefits Division receives your payment. Payments are due the first of every month with a 30-day grace period. All benefits are inactive until payment is received for each month. Payment may be made in advance to cover any or all coupon(s) received, but must be made in full monthly increments. If payment is not received by the end of the 30-day grace period, the employee will be disenrolled and may not re-enroll until the next Open Enrollment Period.

Payment deadlines are strictly enforced. If you do not receive these coupons within one month of signing your Enrollment Worksheet or you change your mailing address, please contact your Agency Benefits Coordinator or the Employee Benefits Division immediately.

MARYLAND STATE RETIREMENT SYSTEM RETIREES

Retirees who are receiving a monthly State retirement allowance, and meet one of the following criteria:

- You left State service with at least 16 years of creditable service with the State;
- You retired directly from State service with at least five years of creditable service with the State;
- You left State service (deferring your retirement allowance) with at least 10 years of State creditable service and within five years of normal retirement age;
- You retired directly from State service with a disability retirement allowance; or
- Your State employment ended prior to July 1, 1984

Full State Subsidy: A State employee who retires with 16 or more years of creditable service or who receives a disability retirement, or who left State service prior to July 1, 1984 receives the full State subsidy provided to an active employee.

Partial State Subsidy: A State retiree otherwise eligible for health benefits with at least five years, but less than 16 years, of creditable service receives a pro-rated subsidy. (Example: 10 years of creditable service would provide 10/16 of the full State subsidy.) This means you would pay a portion of the State subsidy in addition to the regular retiree premium. Your monthly premiums would be higher than those shown in the Premium Rate Table in this book.

Creditable service is determined by the Maryland State Retirement Agency.

Coupons and Payments: If your retirement allowance is not large enough to cover any or all of your monthly premiums, you will be billed for the plan premiums that could not be deducted. Partial plan premiums will not be deducted. You will receive coupons for the six-month period of July – December in August and for the six-month period of January – June in February for the premiums that were not deducted from your monthly retirement allowance. Premium payments are due on the first of every month, with a 30-day grace period. (Exception: July and January premiums are due upon receipt of the coupons, with a 30-day grace period.) If payment is not received by the end of the grace period, you will be disenrolled from the plan/s for which payments were not received and will not be permitted to re-enroll until the next Open Enrollment period. Payment deadlines are strictly enforced.

Beneficiaries of Deceased State Retirees

Surviving beneficiaries of deceased State retirees who:

- Are receiving a monthly State retirement allowance as the surviving beneficiary of a deceased retiree who had selected Retirement Option 2, 3, 5, or 6; and
- Meet the dependent eligibility criteria for health benefits.
- If the beneficiary is a child, the child will only be eligible for subsidized health benefits as long as they meet the dependent eligibility requirements for children. When the child no longer meets the dependent eligibility criteria for children and subsidized health benefits end, non-subsidized benefits under COBRA are available for up to 18 months.

State Subsidy: The eligible beneficiary will be provided the same State subsidy that was provided to the retiree. A surviving spouse (beneficiary) may only cover dependents that would be dependents of the original retiree if he/she were still living.

If the beneficiary was enrolled in dependent term life insurance at the time of the retiree's death, that policy must be converted through the term life insurance plan within 30 days in order to continue term life insurance coverage. Plan names and phone numbers are located on the back cover of this book.

Surviving beneficiaries of retirees who chose Retirement Option 1, 4, or 7 and who were covered as eligible dependents at the time of the retiree's death will only be eligible for non-subsidized health benefits under COBRA for a limited time. This does not apply to retirees in the Law Enforcement Officers Pension System, the Judicial Pension System, or the Legislative Pension Plan.

Optional Retirement Program (ORP) Retirees

There are special rules governing the eligibility and costs of health benefits for ORP Retirees, including Teachers Insurance and Annuity Association – College Retirement Equities Fund (TIAA-CREF), Valic, Aetna, and American Century.

Optional Retirement Plan (ORP) retirees who retired directly from and:

- had at least five years of State service with a Maryland State institution of higher education; or
- ended State service with a Maryland State institution of higher education with at least 10 years of service and were at least age 57; or
- ended service with a Maryland State institution of higher education with at least 16 years of service.

ORP retirees who did not retire directly from a Maryland State institution of higher education, but meet other eligibility requirements above, may participate in the State Retirees Health Benefits Program, but with no State subsidy. ORP retirees with at least 25 total years of service with the State, in the Executive, Judicial or Legislative Branch, are not required to retire directly from a Maryland State institution of higher education in order to participate in the Health Benefits Program with full State subsidy.

ORP retirees who are not eligible to participate in the State Retirees Health Benefits Program may continue their benefits under COBRA for up to 18 months.

Documentation for New ORP Retirees: The Agency Benefits Coordinator must forward the Benefit Enrollment Worksheet along with a letter certifying the employee's total number of years and months of service with the Maryland State institution of higher education and the date the employee is retiring or leaving State service. Also, a letter from the Optional Retirement Plan certifying the date that the retiree will begin receiving an annuity payment is required for State subsidy. Continued annuity payments from the ORP only are required for continued State subsidy.

Individual Subsidy for ORP Retirees:

- Full State subsidy for Individual coverage is available to ORP retirees who have at least 16 years of service with a State institution of higher education, and retire directly from service with the State institution of higher education.
- Partial State subsidy for Individual coverage is available to ORP retirees who have at least five, but less than 16 full years of service with a State institution of higher education, and retire directly from service with a State institution of higher education.

Dependent Subsidy for ORP Retirees:

- Full State subsidy for eligible dependents is available to ORP retirees who have at least 25 years of service with the State, in the Executive, Judicial or Legislative Branch.
- ORP retirees with less than 25 years of State service may enroll eligible dependents under their retiree coverage, but no State subsidy will be provided for the dependent's portion of the premium. The ORP retiree must pay the entire difference in costs between their Individual coverage premium and the full premium for the higher level of coverage.

If you (a) have less than 16 years of service with a State institution of higher education and have Individual coverage, or (b) have less than 25 years of State service with a higher level of coverage, or (c) did not retire directly from a Maryland State institution of higher education, your monthly premiums will be higher than those shown in the Premium Rate Table in this book.

Coupons and Payments: A letter will be mailed to all ORP retirees at the address on file with the Employee Benefits Division, along with payment coupons, which must be submitted with the premium payments. Benefits will be effective as of the date noted on your letter, but no claims will be paid until the Employee Benefits Division receives your payment. Payments are due the 1st of every month with a 30-day grace period. All benefits are inactive until payment is received for each month. Payment may be made in advance to cover any or all coupons received, but must be made in full monthly increments. If payment is not received by the end of the month, benefits will be cancelled. If benefits are cancelled, you may reenroll during the next Open Enrollment period. If you do not receive your coupons within one month of a new plan year or change in coverage, or up to two weeks after your retirement date, please contact the Employee Benefits Division at the number listed on the back cover of this book. Payment deadlines are strictly enforced.

Beneficiaries of Deceased ORP Retirees

Upon the death of an ORP retiree with at least 25 years of State service, the named beneficiary may continue coverage with the State subsidy, provided that the beneficiary continues to receive a periodic distribution under an ORP and meets dependent eligibility requirements for health benefits. A surviving spouse (beneficiary) may only cover dependents that would be dependents of the original retiree if he/she were still living.

Effective October 1, 2001, upon the death of an ORP retiree with less than 25 years of State service, the named beneficiary may continue coverage with no subsidy, provided that the beneficiary continues to receive a periodic distribution under an ORP and meets dependent eligibility requirements for health benefits. A surviving spouse (beneficiary) may only cover dependents that would be dependents of the original retiree if he/she were still living.

Dependents of Employees and Retirees

- **Unmarried children of an employee or retired employee until the end of the calendar year in which the child becomes 19 years old. These children include:**
  1. A blood descendent of the first degree;
  2. A legally adopted child (including a child living with the adopting parents during the period of probation);
  3. A stepchild residing in the household of the employee or retired employee; and
  4. A child permanently residing in the household of the employee or retired employee is the head, and who is being supported solely by the employee or retired employee, provided that the employee or retired employee is related to the child by blood or marriage or is the child's legal guardian.
- An unmarried child 19 years old or older, who is incapable of self-support because of mental or physical incapacity that began before the end of the calendar year of the child's 19th birthday, and who is residing with the employee or retired employee and is dependent for support upon the employee or retired employee.
- An unmarried child who is a full-time student attending an accredited educational institution for not less than 12 credit hours a semester, and who is dependent upon the employee or retired employee for support, until the end of the calendar year in which the child becomes 23 years old, or any unmarried child 23 years old or older who is incapable of self-support because of mental or physical incapacity that began while the child was a full-time student and before the child's 23rd birthday.

DUPLICATE COVERAGE

A husband and wife who are both active State employees and/or retirees may NOT have duplicate coverage under any plan by covering each other under separate enrollments. Also, children of two State employees and/or retirees may NOT be covered twice under both parents' plans. It is the employee's responsibility to file an Enrollment Worksheet to add or delete dependents within 60 days of any qualifying event (age limitation, marriage, birth, divorce, death, etc.)

Failure to delete ineligible dependents may result in disciplinary action, termination of employment, and/or criminal prosecution. IF YOU ATTEMPT TO ADD AN INELIGIBLE PERSON TO YOUR COVERAGE, OR IF YOU FAIL TO REMOVE A DEPENDENT WHO IS NO LONGER ELIGIBLE, YOU WILL BE REQUIRED TO PAY THE FULL INDIVIDUAL PREMIUM FOR THE INELIGIBLE PERSON, REGARDLESS IF CLAIMS WERE PAID OR NOT.

Required Documentation for Dependents

Documentation is required from employees/retirees in order to enroll all dependents. The following chart provides a listing of the documents needed to enroll a dependent. Photocopies are acceptable. Outside of Open Enrollment, a documented qualifying event must occur to add or delete a dependent. Foreign Documents must be translated into English by an official translator other than the employee/retiree or spouse, available at any college or university.

REQUIRED DOCUMENTATION FOR DEPENDENTS

FOR SPOUSE

- State Official Marriage Certificate (Must be certified by the appropriate State or County official (e.g., Clerk of Court)):
  1. from the court in the county or city in which the marriage took place; or
  2. from the Maryland Division of Vital Records for marriages that occurred at least 6 months prior; or
  3. from the Department of Health and Mental Hygiene (DHMH) website: www.dhmh.maryland.gov (click on Online Services).

To remove a spouse from your plan outside of the Open Enrollment period (either one):

- Limited Divorce, Legal Separation Decree (must be signed by a Judge), or
- Divorce Decree (must be signed by a Judge)

NOTE: A SEPARATION ORDER OR AGREEMENT IS NOT A CHANGE IN FAMILY STATUS PERMITTING A MID-YEAR CHANGE IN BENEFITS ELECTIONS.

FOR UNMARRIED CHILDREN

For Natural/Biological Child:

- Natural/Biological Child's Official State Birth Certificate (which must show the State employee/retiree as parent) and
- Tax Affidavit

For Adopted Child:

- After adoption: copy of final adoption decree signed by a Judge or a State Issued Birth Certificate (showing the State employee/retiree as the parent) and Tax Affidavit.
- Pending Adoption: Notice of placement for adoption provided on adoption agency letterhead or copy of court order placing child pending final adoption and Tax Affidavit.

NOTE: FOR FOREIGN ADOPTIONS, DOCUMENTATION OF ENTRY INTO UNITED STATES IS ALSO REQUIRED AND ALL DOCUMENTATION MUST BE TRANSLATED INTO ENGLISH.

For Stepchild: (must reside with the employee/retiree)

- Copy of Child's Official State Birth Certificate (must indicate spouse as parent)
- Copy of official State marriage Certificate
- Applicable Divorce Decree or Legal Custody Papers
- State Affidavit for Step-Children
- Tax Affidavit

NOTE: IF NO DIVORCE DECREE OR CUSTODY PAPERS ARE AVAILABLE, YOU MUST ATTACH PROOF OF THE STEPCHILD'S RESIDENCE WITH THE EMPLOYEE/RETIREE (E.G. SCHOOL RECORDS, DRIVERS LICENSE, DAYCARE RECORDS, ETC.)

For Legal Ward:

- State Affidavit certifying permanent residence and support; and
- Tax Affidavit; and
- Either:

Copy of Court Order signed by a judge or other court official confirming that the employee/retiree has permanent legal custody of the child by a court order of custody or guardianship, or
Copy of will providing testamentary appointment, confirming that the employee/retiree has legal custody of the child.

For Grandchild and other Dependent Child Relatives:
Copy of child's Official State Birth Certificate; and
State Affidavit certifying residence and sole support; and
Tax Affidavit; and
Either:

1. Proof of relation by blood (copy of child's parent's and other relative's Official State Birth Certificate(s)) or marriage (copy of marriage certificates to show relationship to employee/retiree if necessary), or
2. Copy of guardianship order showing the employee/retiree is the child's legal guardian.

NOTE: BIRTH CERTIFICATES AND MARRIAGE CERTIFICATES MUST SHOW LINE OF RELATIONSHIP TO EMPLOYEE/RETIREE. GRANDCHILD'S BIRTH CERTIFICATE MUST LIST EMPLOYEE/RETIREE'S CHILD AS GRANDCHILD'S PARENT.

For Medical Child Support Order:

- Copy of Court Order requiring employee/retiree to provide support and health coverage, signed by the child support officer or Judge; and
- State Official Birth Certificate (must indicate State employee/retiree as parent); and
- Tax Affidavit.

For Disabled Child:

- In addition to the required documentation for a dependent child, a physician certification/verification of permanent disability (Verification of the disability will be required every 2 years)

For Dependents age 19-23: (After the end of the calendar year in which the child turns 19 through the end of the calendar year the child turns 23)

- In addition to the required documentation for a dependent child, certification of student status (certification will be required twice a year in January and September).

HOW TO RECEIVE MEDICAL PLAN BENEFITS

Once enrolled in the plan of your choice, you will receive identification cards in the mail. Take these cards with you every time you receive medical services. Depending on what type of medical plan you choose, the way you receive medical services and how much you pay at the time of service will vary. It is your responsibility to select the benefits plan that best suits your service and financial needs.

There are no pre-existing condition clauses for any of the medical plans, but there are other exclusions. Please contact the medical plans for further information on coverage exclusions, limitations, determination of medical necessity, preauthorization requirements, etc.

Preferred Provider Organization (PPO): This plan allows you to choose any doctor you want at the time of service. Simply present your card to the provider. If your doctor is a participating physician in the PPO network, you will pay a co-payment at the time of service. The co-payment will be $15 for a Primary Care Physician, $25 for a Specialist.

If the doctor is not a participating PPO physician, you may have to pay the entire fee at the time of service and submit a claim for consideration. This amount will be applied toward your plan year deductible ($250/individual, $500/family). After you have reached your plan year deductible, your PPO plan will pay 80% of the plan's allowed amount. You are responsible for the remaining 20% of the allowed amount as well as any fees above the plan's allowed amount, up to the non-PPO physician's charge.

If you receive services from a non-participating physician, you may end up paying more than the plan's allowed amount. For example, if you receive services from a non-participating provider who charges $1500 for service, but the plan only allows $1000 for that service, you are responsible for the difference, up to the provider's full charge.

Actual Charges:

$1500 Amount non-participating provider charges for service
$-500 (Plan Reduction) Member liable for this cost

What your plan covers:

$1000 Plan's allowed amount for this service
$-250 Individual Deductible paid by you for using a non-participating provider

$ 750 Plan pays 80% of allowed charges
$ -150 20% coinsurance paid by you (this is also the amount applied against your out-of-pocket annual maximum)

$ 600 Amount plan will pay after all deductibles and co-payments have been paid

What you owe to the Non-participating provider: $900

Point-of-Service Plan (POS): This plan is a Managed Care or Health Maintenance Organization (HMO) type plan of In-Network benefits, with the option to choose Out-of-Network Services without referral from your Primary Care Physician. You must choose a Primary Care Physician for all In-Network Services. When you use your In-Network benefits, if receiving care from your Primary Care Physician, you only pay the required co-payment at the time of service. You also may choose to receive treatment Out-of-Network without obtaining preauthorization from your Primary Care Physician. This is called "self-referral". The POS option gives you the freedom to choose your own provider, subject to payment of an upfront $250 deductible per plan year and 20% coinsurance.

Health Maintenance Organization (HMO): All benefits through an HMO are managed care. The HMO will only cover In-Network benefits and emergency benefits. If you enroll in this plan, you must choose a Primary Care Physician. Choose carefully, because your medical services will be rendered by and coordinated through this provider. When you receive services In-Network from your Primary Care Physician, you will pay a $15 co-payment. If your Primary Care Physician and plan authorize care from a Specialist, your co-payment will be $25.

Not all participating physicians are listed in directories provided by the plans. Please call the plan to find out if a certain physician participates in any of the plans offered. Do not rely on the physician's office for current information. Please see the back of this book for Plan Phone Numbers and website information.

The following chart is a summary of generally available benefits and does not guarantee coverage. To ensure coverage under any plan, contact that plan before obtaining any services or treatment. Call the plan for more information on coverage, limitations, exclusions, determinations of medical necessity, and preauthorization requirements. In addition, you will receive a description of coverage book from the plan in which you enroll that will provide details on your plan coverage. The percentages referred to in this chart are percentages that the plan will pay based upon the plan's maximum allowed amount. A non-participating Out-of-Network provider may charge more than the plan's allowed amount. You are responsible for any fees above the plan's allowed amount.

STANDARD BENEFITS CHART FOR MEDICAL PLANS

Benefit	PPO In-Network Coverage	PPO Out-of-Network Coverage	POS In-Network Coverage	POS Out-of-Network Coverage	HMO Coverage (All care must be preauthorized)
Deductibles Individual Family	None None	$250 $500	None None	$250 $500	None None
Out-of-Pocket Maximums* Individual Family	None	$3000 Individual $6000 Family	None	$3000 Individual $6000 Family	None
***Any fees above the plan Allowed Amount are not counted toward the Out-of-Pocket Maximum.**					
Lifetime Maximums	The Lifetime Maximum per each covered individual (i.e. per employee or retiree, spouse, and child) is $2 million per lifetime, for PPO and POS membership. Unlimited for the HMOs.				
Physicians Primary Care Office Visit	100% after $15 co-pay	80% after deductible	100% after $15 co-pay	80% after deductible	100% after $15 co-pay
Specialist Office Visit	100% after $25 co-pay	80% after deductible	100% after $25 co-pay	80% after deductible	100% after $25 co-pay
Routine Annual GYN Exam (including Pap test)	100% after $15 co-pay	80% after deductible	100% after $15 co-pay when preauthorized by Plan	80% after deductible	100% after $15 co-pay when preauthorized by Plan
Inpatient Care (Requires Preauthorization)	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Outpatient Surgery (may require Preauthorization)	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Hospitalization	100% for 365 days	80% after deductible; 100% after emergency admission	100% when preauthorized by Plan	80% after deductible; 100% after emergency admission	100% when preauthorized by Plan
Surgery (subject to Preauthorization)	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Anesthesia Services	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Maternity Benefits	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan

The following chart is a summary of generally available benefits and does not guarantee coverage. To ensure coverage under any plan, contact that plan before obtaining any services or treatment. Call the plan for more information on coverage, limitations, exclusions, determinations of medical necessity, and preauthorization requirements. In addition, you will receive a description of coverage book from the plan in which you enroll that will provide details on your plan coverage. The percentages referred to in this chart are percentages that the plan will pay based upon the plan's maximum allowed amount. A non-participating Out-of-Network provider may charge more than the plan's allowed amount. You are responsible for any fees above the plan's allowed amount.

STANDARD BENEFITS CHART FOR MEDICAL PLANS

Benefit	PPO In-Network Coverage	PPO Out-of-Network Coverage	POS In-Network Coverage	POS Out-of-Network Coverage	HMO Coverage (All care must be preauthorized)
Newborn Care	100%	80% after deductible	100% for enrolled newborn when preauthorized by Plan	80% after deductible	100% for enrolled newborn when preauthorized by Plan
Contact plan to confirm if your hospital's Neonatal Unit participates in the Plan. If the Neonatal Unit and its physician's do not participate with the plan, you will be responsible for any balances up to the charge of the Neonatal Unit's providers. The plan will only pay these providers under the "Out-of-Network Coverage" benefits. (Newborn children must be enrolled within 60 days of birth).					
Diagnostic Lab & X-ray	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Chiropractic Services	100% after $20 co-pay	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Acupuncture Services for Chronic Pain Management	100% after $20 co-pay	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Whole Blood Charges	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Medical Supplies	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
(Includes but not limited to surgical dressings; casts; splints; syringes; dressings for cancer, burns or diabetic ulcers; catheters; colostomy bags; oxygen; supplies for renal dialysis equipment & machines; and all diabetic supplies as mandated by Maryland law) **Contact plan for details on covered items.**					
Organ Transplants					
•Per calendar year for cornea, kidney, and bone marrow	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
•Per 365 days up to $1 million per heart, heart-lung, single or double lung, liver, and pancreas	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan

The following chart is a summary of generally available benefits and does not guarantee coverage. To ensure coverage under any plan, contact that plan before obtaining any services or treatment. Call the plan for more information on coverage, limitations, exclusions, determinations of medical necessity, and preauthorization requirements. In addition, you will receive a description of coverage book from the plan in which you enroll that will provide details on your plan coverage. The percentages referred to in this chart are percentages that the plan will pay based upon the plan's maximum allowed amount. A non-participating Out-of-Network provider may charge more than the plan's allowed amount. You are responsible for any fees above the plan's allowed amount.

STANDARD BENEFITS CHART FOR MEDICAL PLANS

Benefit	PPO In-Network Coverage	PPO Out-of-Network Coverage	POS In-Network Coverage	POS Out-of-Network Coverage	HMO Coverage (All care must be preauthorized)
Durable Medical Equipment	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Contact plan for further details on covered items					
Chemo-Therapy/ Radiation	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Contact plan for further details					
Benefit Therapies (See Below for further information on Therapies)	100% after $25 co-pay when preauthorized by Plan	80% after deductible	100% after $25 co-pay when preauthorized by Plan	80% after deductible	100% after $25 co-pay when preauthorized by Plan
•Physical Therapy (PT) & Occupational Therapy (OT) (PT/OT services must be pre-certified after the 6th visit, based on medical necessity; 50 visits per year combined for PT/OT/Speech Therapy).					
•Speech Therapy (must be pre-certified from the first visit, with exceptions and close monitoring for special situations (e.g., trauma, brain injury) for additional visits).					
Private Duty Nursing (Must be preauthorized by all plans)	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Contact plan for further details					
Second Opinion (Surgical)	100%	100%	100%	100%	100% when preauthorized by Plan, or when required by Plan
Ambulance Services	100% for medical emergencies	100% for medical emergencies	100% for medical emergencies	100% for medical emergencies	100% for medical emergencies
Urgent Care Centers	$20 co-pay	80% after deductible, plus $20 co-pay	$20 co-pay	80% after deductible, plus $20 co-pay	$20 co-pay

The following chart is a summary of generally available benefits and does not guarantee coverage. To ensure coverage under any plan, contact that plan before obtaining any services or treatment. Call the plan for more information on coverage, limitations, exclusions, determinations of medical necessity, and preauthorization requirements. In addition, you will receive a description of coverage book from the plan in which you enroll that will provide details on your plan coverage. The percentages referred to in this chart are percentages that the plan will pay based upon the plan's maximum allowed amount. A non-participating Out-of-Network provider may charge more than the plan's allowed amount. You are responsible for any fees above the plan's allowed amount.

STANDARD BENEFITS CHART FOR MEDICAL PLANS

Benefit	PPO In-Network Coverage	PPO Out-of-Network Coverage	POS In-Network Coverage	POS Out-of-Network Coverage	HMO Coverage (All care must be preauthorized)
Emergency Room (ER) Services-Inside and Outside of Service Area	100% after $50 co-payment for ER Facility Care and $50 co-payment for ER Physician services. Co-payments are waived if admitted. If criteria are not met for a medical emergency, plan coverage is 50% of allowable amount, plus the two $50 co-payments.	100% after $50 co-payment for ER Facility Care and $50 co-payment for ER Physician services. Co-payments are waived if admitted. If criteria are not met for a medical emergency, plan coverage is 50% of allowable amount, plus the two $50 co-payments.	100% after $50 co-payment for ER Facility Care and $50 co-payment for ER Physician services. Co-payments are waived if admitted. If criteria are not met for a medical emergency, plan coverage is 50% of allowable amount, plus the two $50 co-payments.	100% after $50 co-payment for ER Facility Care and $50 co-payment for ER Physician services. Co-payments are waived if admitted. If criteria are not met for a medical emergency, plan coverage is 50% of allowable amount, plus the two $50 co-payments.	100% after $50 co-payment for ER Facility Care and $50 co-payment for ER Physician services. Co-payments are waived if admitted. If criteria are not met for a medical emergency, plan coverage is 50% of allowable amount, plus the two $50 co-payments.

NOTE: Emergency Services or Medical Emergency: Health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

1. Placing the patient's health in jeopardy;
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Contact Plan for further details.

Mental Health/Substance Abuse	**NOT COVERED BY PLAN** Covered by State's Mental Health Plan APS	**NOT COVERED BY PLAN** Covered by State's Mental Health Plan APS	**NOT COVERED BY PLAN** Covered by State's Mental Health Plan APS	**NOT COVERED BY PLAN** Covered by State's Mental Health Plan APS	100% for inpatient care up to 365 days when preauthorized by Plan. 80% for outpatient care, visits 1-5; 65% for outpatient care, visits 31 + per calendar year.

NOTE: SEE MENTAL HEALTH/SUBSTANCE ABUSE SECTION OF THIS BOOK FOR FURTHER INFORMATION ABOUT USING APS. (NOT APPLICABLE TO HMO PLANS).

The following chart is a summary of generally available benefits and does not guarantee coverage. To ensure coverage under any plan, contact that plan before obtaining any services or treatment. Call the plan for more information on coverage, limitations, exclusions, determinations of medical necessity, and preauthorization requirements. In addition, you will receive a description of coverage book from the plan in which you enroll that will provide details on your plan coverage. The percentages referred to in this chart are percentages that the plan will pay based upon the plan's maximum allowed amount. A non-participating Out-of-Network provider may charge more than the plan's allowed amount. You are responsible for any fees above the plan's allowed amount.

STANDARD BENEFITS CHART FOR MEDICAL PLANS

Benefit	PPO In-Network Coverage	PPO Out-of-Network Coverage	POS In-Network Coverage	POS Out-of-Network Coverage	HMO Coverage (All care must be preauthorized)
Extended Care Facility (if medically necessary)	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
(Skilled nursing care and extended care facility benefits is limited to 180 days per plan year so long as skilled nursing care is medically necessary).					
Hospice	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Home Health Care	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
(Home Health Care benefits are limited to 120 days per plan year)					
Mammography	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Certain age restrictions and timeframes apply for screening mammograms. Coverage for screening mammograms varies by age: one baseline (age 35-39): one mammogram every 2 years (40-49): one per year (50+). Diagnostic mammograms have no age limitations. Call your plan to check on your next eligible date.					
Family Planning & Fertility Testing	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
(Family planning benefits include: sperm count hysterosalpingography, eudiometrical biopsy, IUD insertion, vasectomy, and tubal ligation. Only 1 reversal covered per lifetime)					

The following chart is a summary of generally available benefits and does not guarantee coverage. To ensure coverage under any plan, contact that plan before obtaining any services or treatment. Call the plan for more information on coverage, limitations, exclusions, determinations of medical necessity, and preauthorization requirements. In addition, you will receive a description of coverage book from the plan in which you enroll that will provide details on your plan coverage. The percentages referred to in this chart are percentages that the plan will pay based upon the plan's maximum allowed amount. A non-participating Out-of-Network provider may charge more than the plan's allowed amount. You are responsible for any fees above the plan's allowed amount.

STANDARD BENEFITS CHART FOR MEDICAL PLANS

Benefit	PPO In-Network Coverage	PPO Out-of-Network Coverage	POS In-Network Coverage	POS Out-of-Network Coverage	HMO Coverage (All care must be preauthorized)
In Vitro Fertilization (IVF) and Artificial Insemination **NOTE: CONTACT YOUR PLAN FOR FURTHER DETAILS ON PREAUTHORIZATION REQUIREMENTS:** Member must be married. Not covered for surrogate motherhood.	100% for up to 3 attempts of Artificial Insemination, and 3 attempts of IVF per live birth-per lifetime	80% after deductible for up to 3 attempts of Artificial Insemination, and 3 attempts of IVF per live birth-per lifetime	100% when preauthorized by Plan for up to 3 attempts of Artificial Insemination, and 3 attempts of IVF per live birth-per lifetime	80% after deductible for up to 3 attempts of Artificial Insemination, and 3 attempts of IVF per live birth-per lifetime	100% when preauthorized by Plan for up to 3 attempts of Artificial Insemination, and 3 attempts of IVF per live birth-per lifetime

In-Vitro Fertilization (IVF) and Artificial Insemination (AI) benefits are available for a married (as recognized by the laws of Maryland) woman if she was infertile:

- throughout the most recent two (2) years of marriage to the same man; or
- her infertility is due to endometriosis, exposure in womb to diethylstilbestrol (DES), or blockage of or surgical removal of one or more fallopian tubes; or
- male infertility is the documented diagnostic cause.

The patient's oocytes must be fertilized with the patient's spouse's sperm. In-Vitro Fertilization and Artificial Insemination are covered for a maximum of 3 attempts per procedure.

- The 3 IVF attempts per live birth will not exceed a maximum expense of $100,000 per lifetime.
- The Artificial Insemination attempts must be taken, when medically appropriate, before IVF attempts will be covered.
- THIS IS ONLY A SUMMARY. CONTACT YOUR PLAN FOR FURTHER DETAILS ON PREAUTHORIZATION REQUIREMENTS.

Norplant Surgery Only	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Well-Baby Care: from birth to 2 years: 8 visits. 2-12 years: 1 visit per plan year.	100% after $15 co-pay per visit, to age 12	80% after deductible per visit, to age 12	100% after $15 co-pay per visit, to age 12, when preauthorized by Plan	**NOT COVERED**	100% after $15 co-pay per visit, to age 12, when preauthorized by Plan

Contact plan for further details on eligibility for visits.

The following chart is a summary of generally available benefits and does not guarantee coverage. To ensure coverage under any plan, contact that plan before obtaining any services or treatment. Call the plan for more information on coverage, limitations, exclusions, determinations of medical necessity, and preauthorization requirements. In addition, you will receive a description of coverage book from the plan in which you enroll that will provide details on your plan coverage. The percentages referred to in this chart are percentages that the plan will pay based upon the plan's maximum allowed amount. A non-participating Out-of-Network provider may charge more than the plan's allowed amount. You are responsible for any fees above the plan's allowed amount.

STANDARD BENEFITS CHART FOR MEDICAL PLANS

Benefit	PPO In-Network Coverage	PPO Out-of-Network Coverage	POS In-Network Coverage	POS Out-of-Network Coverage	HMO Coverage (All care must be preauthorized)
Immunizations	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
(Immunizations are only covered as recommended by the American Medical Association and the American Academy of Pediatrics. The immunization benefit covers immunizations required for participation in school athletics and Lyme Disease immunizations when medically necessary. **Contact plan for further details.**					
Physical Exams: 1 every 3 years for all members and their dependents age 13 and older	100% after $15 co-pay	80% after deductible	100% after $15 co-pay if preauthorized by Plan	**NOT COVERED**	100% after $15 co-pay for exam when preauthorized by Plan
Contact plan for further details on time eligibility for physical exams.					
Hearing Examinations and Hearing Aids, including mandated benefit for hearing aids for minor children (ages 0-18) as mandated by Maryland Law effective January 1, 2002, including hearing aids per each impaired ear for minor children.	100% after $15 co-pay for exam. 100% for Basic Model Hearing aid. 1 exam and hearing aid per ear every 3 years for each employee and dependent.	80% after deductible for exam. 100% for Basic Model Hearing aid. 1 exam and hearing aid per ear every 3 years for each employee and dependent.	100% after $15 co-pay for exam when preauthorized by Plan. 100% for Basic Model Hearing aid. 1 exam and hearing aid per ear every 3 years for each employee and dependent.	**NOT COVERED**, except for hearing aids as mandated for minor children (ages 0-18) as mandated by Maryland law effective January 1, 2002.	100% after $15 co-pay for exam when preauthorized by Plan. 100% for Basic Model Hearing aid. 1 exam and hearing aid per ear every 3 years for each employee and dependent.
Allergy Testing	100% after $15 co-pay (primary care physician) or $25 co-pay (specialist)	80% after deductible	100% after $15 co-pay (primary care physician) or $25 co-pay (specialist) when preauthorized by Plan	80% after deductible	100% after $15 co-pay (primary care physician) or $25 co-pay (specialist) when preauthorized by Plan
Diabetic Nutritional Counseling as mandated by Maryland law	100% after $15 co-pay	80% after deductible	100% after $15 co-pay when preauthorized by Plan	80% after deductible	100% after $15 co-pay when preauthorized by Plan

The following chart is a summary of generally available benefits and does not guarantee coverage. To ensure coverage under any plan, contact that plan before obtaining any services or treatment. Call the plan for more information on coverage, limitations, exclusions, determinations of medical necessity, and preauthorization requirements. In addition, you will receive a description of coverage book from the plan in which you enroll that will provide details on your plan coverage. The percentages referred to in this chart are percentages that the plan will pay based upon the plan's maximum allowed amount. A non-participating Out-of-Network provider may charge more than the plan's allowed amount. You are responsible for any fees above the plan's allowed amount.

STANDARD BENEFITS CHART FOR MEDICAL PLANS

Benefit	PPO In-Network Coverage	PPO Out-of-Network Coverage	POS In-Network Coverage	POS Out-of-Network Coverage	HMO Coverage (All care must be preauthorized)
Prescription Drugs	**NOT COVERED UNDER MEDICAL PLAN**				
Dental Services	**NOT COVERED UNDER MEDICAL PLAN**				
Cardiac Rehabilitation	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan

Cardiac Rehabilitation Benefits: 36 sessions in a 12-week period (or on a case-by-case basis thereafter) with physician supervision and in a medical facility; must be medically necessary with physician referral, and with history of heart attack in past 12 months, Coronary Artery Bypass Graft (CABG) surgery, angioplasty, heart valve surgery, stable angina pectoris, compensated heart failure, and heart and lung transplants.

Vision - MEDICAL					
Any services that deal with the medical health of the eye	100% after $15 co-pay (primary care physician) or $25 co-pay (specialist)	80% after deductible	100% after $15 co-pay (primary care provider) or $25 co-pay (specialist) when preauthorized by Plan	80% after deductible	100% after $15 co-pay (primary care provider) or $25 co-pay (specialist) when preauthorized by Plan

Vision – ROUTINE

(Provided by your health plan) – Any services that deal with correcting vision.

Plan Pays Up To: Exam - $45 (Available once every plan year)

Prescription Lenses (per pair) – (Available once every plan year)

- Single Vision - $28.80
- Bifocal, single - $48.60
- Bifocal, Double - $88.20
- Trifocal - $70.20
- Aphakic: Glass - $54.00
  Plastic - $126.00
  Aspheric - $162.00

Frames - $45 (Available once every plan year)

Contacts (per pair, **in lieu of frames and lenses**). (Available once every plan year)

- Medically Necessary - $201.60
- Cosmetic - $50.40

Vision benefits are only available through your health plan. You may obtain vision services from any licensed vision provider, whether in your health plan or not. To obtain vision benefits, you must contact your medical plan for more information. Vision benefits are available once every year.

MENTAL HEALTH/SUBSTANCE ABUSE PLAN

GENERAL DESCRIPTION OF COVERAGE

Mental Health and Substance Abuse plan coverage is included for all individuals and their dependents that are enrolled in a medical plan. However, your Mental Health and Substance Abuse benefits vary depending on the medical plan in which you are enrolled. All mental health/substance abuse coverage for PPO and POS plans is managed by APS Healthcare, Inc. (APS). Mental health/substance abuse coverage for HMO plans is managed by the HMO. You cannot obtain mental health and substance abuse benefits through the State benefits program, if you do not enroll in a State medical plan.

HOW TO RECEIVE MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

HMO Medical Plan: Your mental health and substance abuse services must be authorized by your HMO. Please contact your medical plan for more details.

STANDARD MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS CHART FOR INDIVIDUALS ENROLLED IN HMO MEDICAL PLANS

Benefits	**In-Network** **All of your mental health and substance abuse benefits are provided through your HMO participating providers and must be preauthorized by your HMO.**	**Out-of-Network** **Not covered**
Inpatient Care, including residential crisis services	100% for up to 365 days/plan year if approved by the HMO	Not Covered
Outpatient Care	80% for HMO-approved outpatient visits. #1 - 5 per plan year; 65% for HMO-approved outpatient visits. #6 - 30 per plan year; 50% for HMO approved outpatient visits. #31 or more per plan year.	Not-Covered

Consult your HMO plan for more details on covered services

PPO and POS Medical Plans: Your mental health and substance abuse benefits are provided by APS. To maximize your benefits, you must contact APS before receiving any services. The professionals at APS will work with you to select an appropriate referral for care. Your mental health and substance abuse benefits include coverage for the following types of treatment:

- Inpatient facility and professional services,
- Partial hospitalization, and
- Outpatient facility and professional services.

Your primary care physician in the PPO or POS plan cannot treat or refer you for mental health or substance abuse treatment. You must contact APS.

STANDARD MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS CHART FOR INDIVIDUALS ENROLLED IN PPO OR POS MEDICAL PLANS

Benefits	In-Network: Care Preauthorized	In-Network: Care Not Preauthorized	Out-of-Network: Care Preauthorized	Out-of Network: Care Not Preauthorized	Coverage Limits
Outpatient Facility/ Office and Professional Services, including Intensive Outpatient**	80% (first 5 visits) 65% (next 25 visits) 50% (further visits) of APS's negotiated fee maximum.	40% (first 5 visits) 32.5% (next 25 visits) 25% (further visits) of APS's negotiated fee maximum.	40% (first 5 visits) 32.5% (next 25 visits) 25% (further visits) of APS's negotiated fee maximum.	20% (first 5 visits) 16.25% (next 25 visits) 12.5% (further visits) of APS's negotiated fee maximum.	No limit on the number of medically necessary/ treatable visits per year. Benefit reduction if no preauthorization is obtained. No limit on out-of-pocket expenses.
ALL PERCENTAGES REFER TO APS HEALTHCARE, INC.'S NEGOTIATED FEE MAXIMUMS. All services must be deemed medically necessary by APS Healthcare, Inc. to obtain any benefits. **Intensive Outpatient Services (IOP) requires pre-authorization regardless of in – or out-of-network provider status.					
Outpatient Medication Management Services	100% of APS's negotiated fee maximums after a $20 co-pay is met.	50% of APS's negotiated fee maximum.	50% of APS's negotiated fee maximum.	25% of APS's negotiated fee maximum.	No limit on the number of medically necessary visits per year. Benefits reduction if preauthorization is not obtained. No limit on out-of-pocket expense.
Inpatient Facility and Professional Services and Partial hospitalization Services and residential crisis services	100% of APS's negotiated fee maximum.	**NOT COVERED**	80% of APS's negotiated fee maximum.	**NOT COVERED**	No benefit coverage if preauthorization is not obtained, regardless of whether provider is in-network or out-of-network. **Out of Network Expenses**: A Co-insurance expense during any one-inpatient stay is limited to $1,500 per member. Member may be liable for any expenses incurred beyond allowed amounts. No limit to medically necessary and treatable preauthorized inpatient days. Sixty days per benefit period for partial hospitalization.

- ALL PERCENTAGES REFER TO APS HEALTHCARE, INC.'S NEGOTIATED FEE MAXIMUMS
- All services must be deemed medically necessary by APS Healthcare, Inc. to obtain any benefits.
- Covered charges for mental health and substance abuse are the same.
- Substance Abuse Detoxification and Rehabilitation are covered under inpatient, partial hospitalization, or outpatient services when medically necessary.
- To receive maximum benefits, care must be preauthorized by calling APS Health care, Inc. at 1-877-239-1458

If you obtain services without preauthorization from APS, your benefits will be reduced by 50% for medically necessary OUTPATIENT services and you will receive no benefits for INPATIENT facility and professional services. You will receive the maximum benefits if you receive care from a provider that has been preauthorized by calling the APS Help Line. The APS team members include member referral and customer service representatives, and mental health professionals experienced in handling mental health and substance abuse issues.

If you experience a non-life threatening emergency or crisis, you will need to contact the APS help line for immediate assistance. If you experience a life-threatening emergency, you should seek treatment at the nearest emergency room. You must notify APS within 24 hours of an emergency admission to certify your care. APS team members are available 24 hours a day, seven days a week, 365 days a year.

Claims processing for In-Network service: If you receive preauthorized services from an in-network provider, you do not have to file any claims. If services are not preauthorized, you may have to file a claim with an itemized bill to APS for reimbursement. Please be aware that providers may include on the bill both medical and mental health services. Medical service charges must be submitted to your medical plan, and mental health charges must be submitted to APS. Please call APS for further information on filing claims.

Claims processing for Out-of-Network Services: Your provider may ask you to pay the bill at the time of service.

You must pay the provider and submit a claim form and an itemized bill to APS for reimbursement. The itemized bill should be on the provider's letterhead/stationery and include:

- Diagnosis and type of treatment rendered (including CPT code);
- Charges for the services performed;
- Date of service; and
- Patient's name and date of birth and subscribers Social Security number.

After you have completed the claim form and attached the itemized bill, mail the information directly to:

APS Healthcare, Inc.
SOM Claims
P.O. Box 1440
Rockville, MD 20849-1440.

APS will send the payment for covered services directly to the subscriber's address on file with the Employee Benefits Division. You will receive an Explanation of Benefits (EOB) any time APS processes a claim. An EOB is not a bill; it is documentation of the action APS has taken on your claim.

PRESCRIPTION DRUG PLAN

FOR INFORMATION ON CO-PAYMENTS, PREFERRED OR NON-PREFERRED BRAND-NAME DRUGS REQUIRING PRIOR AUTHORIZATIONS, LIMITATIONS, STEP THERAPY, AND EXCLUSIONS:	**Caremark Prescription Plan Hotline: 1-800-345-9384** **Caremark Website for State Members: https://maryland.advancerx.com** **For Open Enrollment questions and to check co-payments, log in as a user at Maryland@testsite.com, password: password1.**
WHERE TO OBTAIN YOUR PRESCRIPTION:	At participating Caremark pharmacies for full benefits.
YOUR SUPPLY PER PRESCRIPTION:	For prescriptions written for less then 45 days, you will pay one co-payment. For prescriptions written for 45-90 days, you will pay 2 co-payments.
YOUR ANNUAL OUT-OF-POCKET MAXIMUM CO-PAYMENT AMOUNTS:	If you and your covered family member's total out-of-pocket co-payments reach $700 in the plan year, you and your covered family members will not pay any more in co-payments for the plan year for covered drugs.
SUBMISSION OF CLAIM FORMS:	At participating Caremark pharmacies: You do not need to submit any claim forms; your prescription is adjudicated electronically at the pharmacy. At nonparticipating pharmacies: You must pay the full cost of the medication at the pharmacy and submit a claim form for reimbursement. You may obtain claim forms at https://maryland.advancerx.com or by calling Caremark toll free at: 1-800-345-9384.
DRUGS REQUIRING PRIOR AUTHORIZATION:	Certain drugs require prior approval before coverage is provided. To initiate a Prior Authorization evaluation, physicians will need to submit additional medical information and must call Caremark at 1-888-413-2723. Pharmacists and physicians will review the medical information to determine if you meet the medical criteria established for coverage of these medications. You will be informed in writing as to whether your request for coverage has been approved or denied. Drugs requiring Prior Authorization include, but are not limited to: Growth Hormones, Retin-A for individuals' age 26 and older, Desoxyn, Dexedrine, and Adderall. Call Caremark or refer to the Caremark website noted above and on the back of this booklet for further information. If coverage is denied, you can choose to fill the prescription but you must pay the full cost of the medication. **The list of drugs requiring Prior Authorization is subject to change. Caremark will notify you in advance of changes if you are taking one of the drugs requiring Prior Authorization.**

QUANTITY LIMITATIONS ("MANAGED DRUG LIMITATIONS") ON CERTAIN DRUGS:

For certain types of prescription drugs, there are limitations placed on the quantity that is covered during a certain period of time, called "Managed Drug Limitations". Managed Drug Limitations are based on FDA approved usage/guidelines for these medications. An example of a drug with a quantity limit is Viagra. Refer to the Caremark website at https://maryland.advancerx.com to verify if your medication will have a quantity limit. For drugs that are subject to quantity limitations, co-payments will be required for the reduced quantities.

The list of drugs with Managed Drug Limitations is subject to change at any time. If you are currently taking a medication that will have a quantity limitation applied, you will receive notification prior to 7/1/2005.

STEP THERAPY FOR CERTAIN DRUGS:

Step Therapy is a process for finding the best treatment while ensuring you are receiving the most appropriate drug therapy and helping to reduce your pharmacy costs.

The first step in the Step Therapy process is usually a treatment that is known to be safe and effective for most people, called "first line" therapy. The next step is "second-line" therapy. "First and second-line" drugs are selected after careful review of medical literature, manufacturer product information, and consultation with medical professionals.

These steps follow the most current and appropriate drug therapy recommendations.

The on-line pharmacy computer will review your records for Step Therapy medications when you go to the pharmacy to fill a prescription. If your prescription is for a Step Therapy medication, the computer will search your prescription records for use of a "first-line" alternative. If the system does not find a prior prescription record for a "first-line" alternative, the Step Therapy medication will not be covered. You will then be required to obtain a new prescription from your physician for one of the "first-line" alternatives, for benefits coverage.

Before coverage of certain drugs is provided, you may need to try other drugs first or your physician may need to submit additional medical information to Caremark for consideration of coverage by calling 1-888-413-2723. Refer to the Caremark website at https://maryland.advancerx.com or call Caremark for more information on Step Therapy.

The list of drugs that require Step Therapy is subject to change. If you are currently taking a medication that is on the Step Therapy list, you will receive notification prior to 7/1/2005.

Benefits continued on page 26

VOLUNTARY SPECIALTY DRUG PHARMACY:

Certain self-administered injectable drugs and specialized/biotech types of drugs can be purchased at Caremark pharmacies that specialize in providing these types of medications (called "Specialty" pharmacies). These include certain anti-neoplastic (cancer-treating) medications, growth hormones, infertility medications, and drugs for multiple sclerosis. Caremark's "Specialty" pharmacists will provide you with overnight delivery of drugs and any necessary supplies, specialized patient education, patient-specific dosing, close patient monitoring, and other services for your special drug needs.

Refer to https://maryland.advancerx.com or call Caremark to find out if your medication is available at the Caremark "Specialty" pharmacy and how you can obtain the additional services available.

VOLUNTARY MAIL ORDER PROGRAM:

You may choose to obtain your prescriptions through a Voluntary Mail Order Program with Caremark. The Voluntary Mail Order Program provides you with the service of having your drugs mailed to your home, and having medications refilled through the Internet and by phone. Caremark provides a 24-hour, toll-free hotline for the Voluntary Mail Order Program.

You may obtain prescriptions for up to a 90-day supply with 2 co-payments.

There are 3 options using the voluntary Caremark Fast Start program:

1. Call toll-free 1-866-273-5268 (TTY assistance call 1- 800-863-5488), and provide your prescription name, doctor's name and phone number, plan participant ID, and payment information. Caremark will contact your physician and take care of the paperwork for you.

2. Visit https://Caremark.com and select the "Start a New Prescription" option. Log in and click the "filling your long-term prescription" or select "Manage Your Prescription". Lastly, follow the prompts and provide the requested information. Caremark will process your request and get in touch with your doctor on your behalf.

3. Get a 90-day prescription from your doctor with as many as three refills (if appropriate). Complete the mail service order form and mail it in with your prescription and payment.

Call Caremark or visit their website for further information about the Voluntary Mail Order Program.

WHAT YOU PAY*:	• $5 Generic drugs • $15 Preferred Brand name drugs** • $25 Non-Preferred Brand name drugs** * If a medication costs less than the co-payment, you pay the actual cost of the medication. ** If you purchase a Brand name drug when a Generic drug is available, you will pay the $15 or $25 co-payment, plus the difference in cost between the Generic Drug and Brand name drug. Call Caremark or visit their website to ask about the Preferred or Non-Preferred status of your prescription drug. Subject to change at any time.
DRUG EXCLUSIONS:	Certain drugs and medications are excluded from coverage, including but not limited to: Over-the-Counter Medications, Vitamins (except for prescribed pre-natal vitamins), Anorectics (Weight-Loss Drugs), and DESI Drugs. **This list of Excluded Drugs is subject to change at any time**. Call Caremark or visit their website for a listing of Excluded Drugs.

DENTAL PLANS

GENERAL DESCRIPTION OF COVERAGE

Dental coverage is available to all individuals who are eligible for health benefits with the State. You must be enrolled in one of the three dental plans offered if you want to have dental benefits.

HOW TO RECEIVE DENTAL PLAN BENEFITS

Dental Health Maintenance Organization Plans (DHMO)

You must select a Primary Dental Office (PDO) from your selected Dental HMO's network of participating dentists when you enroll. You may obtain a Primary Dental Office Form by calling your Dental HMO office. You are free to change your primary provider site selection at any time.

Remember to verify provider participation before seeking care by calling your Dental HMO. Also, before you receive any services, be sure to consult the Schedule of Benefits for the type of dental plan you have chosen to ensure that you have anticipated all out-of-pocket costs and liabilities associated with a particular type of treatment.

How the DHMO Plans Works

There are two dental HMOs available:

- Dental Benefits Provider (DBP)
- United Concordia (UCCI)

The Dental HMOs cover only services from in-network dentists. Call the Dental HMO's or visit their website to obtain information on their in-network dentists.

The Dental Benefits Providers DHMO permits 2 PDOs per family. The selected dentist will provide or arrange for all of the dental care provided for you and your dependents.

Preventive and diagnostic dental care is covered in full, while restorative and other major services are offered at a reduced cost. Orthodontic services are available for both adults and children. (Call the Dental HMO for details and limitations). There are no deductibles and no yearly benefit maximums. A referral is required in order to see a specialist. You must select a primary dental office that coordinates all your dental care and referrals.

The United Concordia DHMO plan offers each family member the option of selecting a different PDO from the dental network, which will provide, or arrange for, all dental care.

Review the Schedule of Benefits for each plan for the co-payment amounts associated with each type of dental service. Services not listed on the Schedule of Benefits are excluded from coverage. The 2 DHMO Schedule of Benefits are located on our website, www.dbm.maryland.gov, and on the DBP and UCCI websites.

Predetermination of Benefits

There is no general requirement for you or your primary dentist to seek predetermination of benefits before treatment starts. However, you are encouraged to do so for major dental procedures so that you and your dentist will know exactly what will be covered and what your financial liability will be.

Out-of-Area Emergencies

Your selected Dental HMO will pay a maximum of $50, subject to your co-payment, for emergency dental services when you are traveling out of the area (more than 50 miles from your dentist's office). In order to receive payment for out-of-area emergency care, you must submit a bill itemizing the charges and services performed. This claim should then be forwarded to your Dental HMO for processing.

DHMO Network

If you reside in an area that does not have a Dental HMO network of dentists or if you are not satisfied with the plan network, please contact the Dental HMO to determine other options. In addition, you may request that the plan evaluate the dentist of your choice for inclusion in the network. However, there is no guarantee that a provider of your request will choose to participate in the plan network. In the Dental HMO plan, you can only receive services from a Dental HMO plan provider. If you move or live outside of the Maryland service area, you cannot be enrolled in the Dental HMO plans.

Dental Preferred Provider Option Plan (DPPO):

How the Dental PPO Plan Works

The Dental PPO plan is available through United Concordia. Under the Dental PPO Plan, you may choose to receive services from an in-network PPO dentist or an out-of network dentist of your choice any time that you receive services. Benefit coverage amounts are higher if you choose an in-network PPO dentist for services. If you use an out-of-network dentist, you will need to file a claim form for reimbursement. No referrals are needed for specialty care. **Orthodontia services are only covered for children age 23 and younger.**

DENTAL HMO FEE SCHEDULE

2 Dental HMOs (DHMOs) are offered:

- Dental Benefits Providers (DBP) DHMO
- United Concordia Companies (UCCI) DHMO

For each covered procedure, you pay only a set co-payment amount. However, you must obtain services from a DBP or UCCI dentist.

Both Dental HMOs cover procedures in the following categories:

Diagnostic and Preventive Services:

Exams, X Rays, Cleanings, Sealants Fluoride Treatments, Other Preventive Care Services, Treatment of Pain

Restorative Services:

Restoration of Teeth, Space Maintainers, Extraction of Teeth, Endodontic (Root Canal) Services, Periodontal Services (including Surgical and Non-surgical services), Oral Surgery

Major Restorative Services:

Crowns, Inlays, Onlays, Bridges, Dentures and their repair

Orthodontic Services (For Both Children and Adults):

Evaluation & Consultation, Orthodontic Treatment, Orthodontic Retention

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For a complete listing of all covered Dental HMO procedures and the set co-payment amounts that you will pay for each procedure, visit the DBM website or the DBP & UCCI websites at:

DBM Website: www.dbm.maryland.gov
(Both the DBP and UCCI Dental HMO Fee Schedules are on the DBM website)

DBP Website: www.dbp-inc.com **UCCI Website: www.ucci.com**

DENTAL PPO SCHEDULE OF BENEFITS

Dental PPO benefits are provided according to the following Schedule of Benefits:
Annual Maximum (paid by the Dental PPO plan per participant) = $1,500

Class I (Preventive)	**Class II** (Basic Restorative)	**Class III** (Major)	**Class IV** (Orthodontia) CHILD ONLY
Preventive Services including, but not limited to: Initial, periodic and emergency examinations, radiographs, prophylaxis (adult and child), fluoride treatments, sealants, emergency palliative treatment, space maintainers. **Coverage:** 100% Allowed Amount **Deductible:** None	**Preventive Restoration Service including, but not limited to:** Fillings, inlays, endodontic services, periodontal services, oral surgery services, general anesthesia, prosthodontic maintenance-relines and repairs to bridge, and dentures. **Coverage:** 70% Allowed Amount **Deductible:** Yes; $50 per individual; 3 deductibles per family per year.	**Major Restorative Services including, but not limited to:** Crowns and bridges, dentures (complete and partial), fixed prosthetics. **Coverage:** 50% Allowed Amount **Deductible:** Yes; $50 per individual; 3 deductibles per family per year. **Coverage:** 50% Allowed Amount	Lifetime maximum per child $2,000

Call or visit the websites listed on the back of this booklet for fee schedule and information on network dentists.

TERM LIFE INSURANCE PLAN

LIFE INSURANCE FOR ACTIVE EMPLOYEES

The Standard Term Life Insurance Plan is available to all **active employees** and their dependents who are eligible for health benefits with the State. New employees have 60 days from their entry on duty date to enroll in the plan.

Employees are eligible for coverage in $10,000 increments up to a maximum of $300,000. Employees may choose up to $50,000 guaranteed coverage for themselves without a Medical History Statement. If you select coverage greater than $50,000 for yourself, you must complete and submit the Medical History Statement to be reviewed for approval by the plan. Medical History Statements are available from your Agency Benefits Coordinator.

Dependent Life Insurance Coverage: Employees can elect dependent coverage in $5,000 increments up to 50% of the employee's coverage up to a maximum of $150,000. Employees may choose up to $25,000 guaranteed coverage for eligible dependents without a Medical History Statement. If you select coverage greater than $25,000 for a dependent, you must complete and submit the Medical History Statement for each dependent whose requested coverage exceeds $25,000 to be reviewed for approval by the plan.

The same dependent eligibility requirements for other plans also apply to the life insurance plan. Dependents with life insurance who become ineligible may contact the plan for information to convert to an individual policy.

Changing Coverage and When Coverage is Effective: If you are currently enrolled in the plan, you may continue at your current coverage level each plan year without Medical Review. If you want to increase your coverage to more than $50,000 during Open Enrollment, regardless of your current coverage amount, you must file a Medical History Statement with the plan. Medical History Statements are available from your Agency Benefits Coordinator. Please note that your increased coverage amount will become effective on the latter of: the first day of the new plan year, the date The Standard approves your medical review, or the date you become "actively at work". If your request for increased coverage is denied, your coverage will remain at your previous amount.

For new enrollment in State term life insurance to begin, you must be "actively at work," in the employ of the State of Maryland, and performing services for compensation on regularly scheduled working days. Regularly scheduled working days do not include holidays, non-work days, vacations, or other scheduled leaves. "Actively at work" means that you have worked at least 20 hours over the last seven consecutive calendar days at either your usual place of employment or away from your usual place of employment at the agency's convenience, and that you are not currently on sick leave or other type of scheduled leave.

Accelerated Benefit: An Accelerated Benefit is available in the event of a terminal illness. An insured employee (or insured spouse) has the option for early access to up to 50% of the face amount of their insurance coverage, if the insured person is medically certified to be terminally ill with less than six months to live, and has at least $20,000 in coverage.

Continuation of Coverage and Waiver of Premium During Total Disability: If you become totally disabled prior to age 60 and are enrolled in the State term life insurance plan as an active State employee on your date of disability, you may be entitled to a Waiver of Premium. Your coverage will continue until the ninth month of your total disability. If you want to apply for a Waiver of Premium, you must submit a Waiver of Premium application to The Standard on the ninth month of your total disability. If approved, your premiums will be waived. Once you are approved for a Waiver of Premium, life insurance coverage for you and your covered dependents will be directly through The Standard. Also, the coverage will end when you reach age 65 or when you are no longer disabled, whichever comes first.

If your request for a Waiver of Premium is denied, your only option for continuation of coverage is to convert to an Individual policy. You will no longer be eligible for term life insurance through the State. Conversion applications are available from your Agency Benefits Coordinator or from the plan. Please note that Waiver of Premium applications will NOT be accepted beyond twelve months from your date of disability.

Previous Waiver of Premium with MetLife: If you already have a Waiver of Premium with Metropolitan Life Insurance Company (MetLife), the former life insurance plan, coverage for you and your dependents is directly through MetLife, and not with the State. Your coverage will end when you reach age 65 or are no longer disabled, whichever comes first. You may then convert to an Individual policy with MetLife. Your coverage does not transfer over to The Standard.

Conversion and Portability of Coverage: An active employee leaving State service has the option under "Portability" to continue their current coverage, along with their dependent coverage, by converting to an Individual policy and paying directly to the plan. Conversion to a non-group policy is available within 31 days of reduction or loss of coverage with the group policy. Call the plan representative at the phone number listed on the back cover for conversion information and rates.

LIFE INSURANCE UPON RETIREMENT

State retirees who retire directly from State service on or after January 1, 1995 may:

- Continue life insurance at the same coverage level, subject to the age-related reduction schedule below.
- Reduce life insurance coverage to a minimum of $10,000, also subject to the age-related reduction.
- Cancel life insurance coverage.
- Convert to an Individual policy.

There can be no break in life insurance coverage between active employment and retirement. If you cancel life insurance coverage at any time after retirement, you cannot reenroll in the life insurance plan.

Dependent Life Insurance Coverage: As a retiree, you may also choose to continue, reduce, or cancel your dependent life insurance coverage for any dependents that were covered as your dependents under the life insurance plan while you were an active employee.

Retirees cannot increase their life insurance coverage or add new dependents to their life insurance coverage upon retirement or at any time after retirement. Retirees who choose to reduce or cancel life insurance will not be permitted to increase coverage or re-enroll in the State life insurance plan in the future.

Automatic Reduction of Benefits for Retirees: Life insurance benefits for retirees will reduce automatically from the original amount, based on the retiree's attained age and the chart below. Dependent coverage also reduces at the same reduction rate as the retiree. New retirees who are at least age 65 at the time of retirement will have an immediate automatic reduction at retirement. Upon an automatic reduction, premiums are based on the reduced coverage amount and the current age bracket of each covered member.

- $65% of original coverage when retiree reaches age 65
- $45% of original coverage when retiree reaches age 70
- $30% of original coverage when retiree reaches age 75
- $20% of original coverage when retiree reaches age 80

Accelerated Benefit: An Accelerated Benefit may be available in the event of a terminal illness. An insured retiree may have the option for early access to up to 50% of the face amount of their insurance coverage, if the insured person retired due to illness, and is medically certified to be terminally ill with less than six months to live, and has at least $20,000 in coverage.

No Duplication of Benefits or Enrollment

You cannot have duplicate life insurance coverage under the State plan. If you and your spouse are both State employees and/or retirees, and you cover yourself for life insurance, you cannot be covered as a dependent of your spouse. Also, children of State employees and retirees cannot have duplicate coverage under both parents. The Standard will only pay benefits in accordance with one policy.

Beneficiaries

The Standard requires a valid beneficiary designation on file. If you do not name a beneficiary, or if you are not survived by one, benefits will distributed according to the order detailed in The Standard's Certificate of Group Coverage as follows: benefits be paid in equal shares to the first surviving class of the following classes: 1) your spouse, 2) your children, 3) your parents, 4) your siblings or 5) your estate. Beneficiary Designation forms for The Standard are available from your Agency Benefits Coordinator or from The Standard.

The Policy number for The Standard is #642220.

Questions?

If you have additional questions about coverage, conversion policies, limitations, definitions, restrictions, terminating events or exclusions, please call the plan at the number located on the back cover of this book.

ACCIDENTAL DEATH AND DISMEMBERMENT PLAN

The Accidental Death and Dismemberment (AD&D) Plan is available to all Active status employees and their dependents who are eligible for health benefits with the State through the Metropolitan Life Insurance Company. The Plan provides benefits in the event of an accidental death or dismemberment. No medical review is required for enrollment in the Plan. This Plan will cover you for accidents that occur at work as well as accidents off the job.

The AD&D Plan has many other benefits in the event of a covered loss. Additional benefits include:

- Exposure and Disappearance
- Waiver of Premium
- Education
- Day Care
- Seat Belt
- Common Disaster
- Emergency Evacuation
- Repatriation of Remains

Benefits will be paid to the Insured Person within 365 days of the date of an accident. The Plan will pay, in one sum, a certain percentage of the Principal Benefit Amount, depending on whether there is a loss of life or some type of dismemberment. If more than one covered loss is sustained during one accident, the Plan will pay all losses to the Principal Sum Amount.

If you choose Family Coverage, benefits for your spouse and eligible dependent children are as follows:

EMPLOYEE STANDARD BENEFITS CHART FOR AD&D PLAN

	Benefit
Loss of Life	100%
Both Hands or Both Feet	100%
Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Entire Sight of One Eye	100%
Speech and Hearing (both ears)	100%
Quadriplegia	100%
Paraplegia	75%
One Hand or One Foot	50%
Entire Sight of One Eye	50%
Speech or Hearing	50%
Hemiplegia	50%
Thumb and Index Finger of Same Hand	25%

STANDARD DEPENDENT BENEFITS CHART FOR AD&D PLAN

Dependent	Benefit
Spouse	55% of Insured Employee's Principal Benefit Amount
Eligible Dependent Children	15% of Insured Employee's Principal Benefit Amount
If no Spouse	Eligible Dependent Children receive 25% of Insured Employee's Principal Benefit Amount *
If no Eligible Dependent Children	Spouse receives 65% of Insured Employee's Principal Benefit Amount

* Maximum benefits available per child is $50,000

NOTE: PLEASE CONTACT METLIFE AT THE TELEPHONE NUMBER LISTED ON THE BACK COVER OF THIS BOOK FOR AN AD&D BENEFICIARY DESIGNATION FORM. YOU MUST COMPLETE AN UPDATED AD&D BENEFICIARY DESIGNATION FORM FOR THE AD&D CARRIER, METLIFE.

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSA) are available to full-time Active employees. Seasonal and temporary employees, graduate students, contractual employees, and retirees are not eligible.

For enrollment in a FSA, you must enroll each year. FSA's will not automatically continue into the next plan year.

GENERAL DESCRIPTION OF FLEXIBLE SPENDING ACCOUNTS

Using a FSA can save most employees 22% to 38% of the cost of eligible out-of-pocket expenses for health and day care services. Each type of FSA has special advantages and restrictions. You may want to discuss your personal situation with a tax advisor before deciding how to make a FSA work for you, as the Internal Revenue Service (IRS) has additional rules that may limit the amount you may select.

All eligible expenses must be incurred within the periods covered by your deductions. The plan year ends each year on June 30th, and claims must be submitted by October 15th of that same year.

When you enroll in a FSA, you must select the amount that will be deducted per pay, regardless of the enrollment method used. You cannot enroll by selecting the annual maximum.

The FSA takes advantage of income tax laws that allow you to pay your share of the cost of your benefits on a tax-free basis.

EXAMPLE:

With a FSA, you don't pay Federal or State income taxes, or Social Security taxes on the money you use.

$1,700	-	**$200**	-	**$340**	=	**$1,160**
Total Monthly Taxable Salary		Flexible Contribution		Taxes (Estimated)		Take home pay

Without a FSA, you are paying taxes on the money you use for eligible expenses.

$1,700	-	**$385**	-	**$200**	=	**$1,115**
Total Monthly Taxable Salary		Taxes (Estimated)		Expenses paid after taxes		Take home pay

In the example above, you save $45 per month or $540 per year in taxes by using a FSA.

There are two types of FSA's available to pay for certain expenses with tax-free dollars. The first is the Health Care Spending Account (HCSA), which is used to cover expenses for you and your eligible dependents such as co-pays, deductibles, co-insurance and other qualified medical expenses not covered under your Health, Prescription Drug or Dental plan. Some non-prescription over-the-counter (OTC) drugs can also be reimbursed.

The second is the Dependent Care Spending Account (DCSA), which is used to cover daycare expenses for your child(ren) less than 13 years of age or other qualified expenses for the care of your eligible tax dependents.

For more information about eligible expenses or eligible tax dependents for either the HCSA or DCSA, please contact the FSA administrator at the telephone number or website listed on the back cover of this book. Their website will also include a listing of expenses that are eligible for reimbursement as defined by the IRS.

Estimate your expenses conservatively. If your eligible expenses do not total the amount in your HCSA by the end of the plan year, you will forfeit the balance left in your account.

Health Care Spending Account

You will need to decide how much money to set aside in an account for the plan year. Your deductions per pay must total between $120 - $3,000 annually for a full plan year. The amount must be calculated and entered as a per pay period deduction.

Health Care FSA:	Minimum	Maximum
Annually	$120.00	$3,000.00
12 Pay period deductions	$10.00	$250.00
24 Pay period deductions	$5.00	$125.00
21 or 22 Pay Faculty (19*) Scheduled deduction	$6.32	$157.89

*For fiscal year 2006, all 21 or 22-pay faculty members must contact the Personnel Office of their respective institution for their pay schedule with multiple deductions. Multiple deduction schedules differ by institution.

Reimbursement: You must submit a claim form and documentation from your healthcare provider, e.g., physician, dentist or pharmacy, to the FSA Administrator. Claims checks will only be issued for an amount of $20 or more.

Dependent Care Spending Account

You will need to decide how much money to set aside in an account for the plan year. Your deductions per pay must total between $120 - $5,000 annually for a full plan year. The amount must be calculated and entered as a per pay period deduction.

Dependent Care FSA:	Minimum	Maximum
Annually	$120.00	$5,000.00
12 Pay period deductions	$10.00	$416.67
24 Pay period deductions	$5.00	$208.33
21 or 22 Pay Faculty (19*) Scheduled deduction	$6.32	$263.15

*For fiscal year 2006, all 21 or 22-pay faculty members must contact the Personnel Office of their respective institution for their pay schedule with multiple deductions. Multiple deduction schedules differ by institution.

Do not include your dependent's health care expenses in your DCSA. Dependents health care expenses should be included in your HCSA.

Reimbursement: You must submit a claim form and documentation from your daycare provider to the FSA Administrator. Funds are not available for reimbursement until they have been deducted. Claims totaling more than your available account balance will be pended until the amount is available in your account. Claims checks will only be issued for an amount of $20 or more.

VOLUNTARY LONG TERM CARE INSURANCE PLAN

Long Term Care is the type of care received, either at home or in a facility, when someone needs assistance with activities of daily living or suffers severe cognitive impairment. However, this is not medical insurance. The Long Term Care Insurance plan (LTC) is offered through Unum Insurance Company of America. Coverage is available to all active employees and State retirees and their family members, including spouses, adult children, siblings, parents (in-laws included) and grandparents (in-laws included). Active employees and their spouses will have premiums payroll-deducted. Eligible State retirees and all other family members will be directly billed for the coverage by UNUM.

Employees are medically underwritten with the exception of newly hired active employees who enroll during their initial 60-day eligibility period. Medical underwriting is also required for enrollment in the Long Term Care Plan for retirees and family members of active employees and retirees. This means you must complete a UNUM Long Term Care Medical Questionnaire. UNUM will evaluate the Medical Questionnaire to determine if the person meets their criteria to be enrolled in the LTC plan.

The Plan Choices

Facility Benefit Duration 3 years or 6 years

Facility Monthly Benefit Amount
$2,500 or $3,000 or $4,500 or $6,000

Plans	**Plan 1**	**Plan 2**	**Plan 3**	**Plan 4**
Long Term Care Facility	100%	100%	100%	100%
Assisted Living Facility	100%	100%	100%	100%
Professional Home Care	50%	50%	50%	50%
Nonforfeiture	N/A	Yes	N/A	Yes
Compound Inflation	N/A	N/A	Yes	Yes

When Benefits Begin – you are eligible for a monthly benefit after:

- You become disabled as defined by the plan;
- You are receiving services in a Long Term Care Facility or Assisted Living Facility, or receiving professional Home Care Services;
- You have satisfied the 90-day Elimination Period; and
- A physician has certified that you are unable to perform, without substantial assistance from another individual, two or more Activities of Daily Living (ADL) for a period of at least 90 days, or that you suffer severe cognitive impairment. You will be required to submit a physician certification every 12 months.

ADL losses and cognitive impairment must occur after the effective date of coverage to qualify for benefits.

Important LTC Definitions

- **Activities of Daily Living (ADLs) are:**
  - Bathing
  - Dressing
  - Toileting
  - Transferring
  - Continence
  - Eating
  - Severe Cognitive Impairment
- **Benefit Duration** – the 3 year or 6 year length of time you purchase to receive benefits at the long-term care facility or nursing home facility level.
- **Assisted Living Facility** – an assisted living facility that is licensed by the appropriate agency (if required) to provide ongoing care and services to a minimum of 10 inpatients in one location.
- **Professional Home Care** – includes visits to your home by a Home Health Care Provider during which skilled nursing care, physical, respiratory, occupational, dietary or speech therapy, or homemaker service is provided.
- **Respite Care** – formal care provided to you for a short period of time to allow your informal caregiver a break from their care giving responsibilities. If you are eligible for a home care monthly benefit but benefits have not yet become payable, payments will be made to you for each day you receive respite care for up to 15 days each calendar year.

  The amount of your payment will equal 1/30th of your home care monthly benefit for each day that you receive respite care.
- **Optional Inflation Protection (compound capped)** – your monthly benefit will increase each year on the Policy Anniversary by 5% at the original Monthly Benefit. Increases will be automatic and will occur regardless of your health whether or not you are disabled. Your premium will not increase due to automatic increases in your Monthly Benefit.
- **Nonforfeiture Benefit (Shortened Benefit Period)** – If your coverage lapses due to nonpayment of premium after your coverage has been in force for five years, you will be eligible for a Nonforfeiture Benefit. This means your coverage will continue in force with the same level of benefits, except for a reduction in your Lifetime Maximum Amount.

Important Information on Enrollment

If you have questions about the Long Term Care Insurance coverage, please call Unum's toll-free service number at 1-800-227-4165. This number will be available through the enrollment period, Monday-Friday, 8 a.m.-8 p.m., Eastern Standard Time.

EFFECTIVE DATES OF COVERAGE

The following rules apply to determine when your coverage for all of the plans described in this booklet begins.

- Open Enrollment period changes have an effective date of the beginning of the next plan year: July 1.
- New Enrollment and authorized Changes of Coverage for active employees have an effective date of either the 1st or 16th of the month depending upon the pay period for which the first deduction is taken.
- New Enrollment and authorized Changes in Coverage for Retirees are always on the 1st of the month depending upon the first deduction taken or when payment is received for direct pay enrollees.

Special Enrollment Instructions

- Active State employees enrolling for the first time must file an Enrollment Worksheet within 60 days of the date of hire. Applications will not be accepted after 60 days. The Agency Benefits Coordinator must sign the Enrollment Worksheet and check the accuracy of the dependent verification documentation before forwarding to the Employee Benefits Division. If an employee wants coverage to begin at the date of hire, the Agency Benefits Coordinator must submit a Retroactive Adjustment with the Enrollment Worksheet.

- Changes in Coverage for Active Employees and Retirees require that an Enrollment Worksheet be filed to change the coverage within 60 days of a qualifying event (i.e. birth, marriage, death, overage dependent, divorce, etc).

- A Retroactive Adjustment form, if needed, should be submitted with the worksheet. Active employees must submit their Enrollment Worksheet to their Agency Benefits Coordinator. Retirees should submit their worksheet to the Employee Benefits Division.

  Only the Employee Benefits Division has authority to modify the changes to your health benefits that you requested. The employee or retiree should send all notifications of changes to the Employee Benefits Division.

- All enrollees (State employees, State retirees, Satellite employees, COBRA enrollees, etc.) have 60 days from the date of birth to add a newborn to their health benefits. If a newborn is not added within 60 days of the birth, you must wait until the next Open Enrollment to enroll the child. It is mandatory that an Enrollment Worksheet and Retroactive Adjustment form must be filed even if you already have Family Coverage. Temporary documentation of the child's birth (such as hospital discharge papers, copy of the child's hospital ID bracelet or footprint) must be submitted with the worksheet. An official State birth certificate must be submitted within 60 days of the date of receipt of the temporary documentation. Active employees should meet with their Agency Benefits Coordinator and Retirees and COBRA enrollees should call the Employee Benefits Division for assistance.

The Employee Benefits Division must be notified in writing through an Enrollment Worksheet when you need to remove an ineligible dependent (e.g. divorced spouse, married dependent, child over 19 not in school, etc.). The notification must include all necessary documentation. Failure to delete ineligible dependent(s) within 60 days of the qualifying event will result in your being responsible for the total premium cost for coverage of the ineligible dependent(s) regardless of whether claims were submitted or paid. In addition, keeping an ineligible dependent on your coverage may result in disciplinary action, termination of employment and/or criminal prosecution.

Effective Dates Termination of Coverage

Terminations of coverage are only permitted during Open Enrollment or within 60 days of a qualifying event.

When you terminate active employment your coverage continues in effect through the end of the time period covered by your last deduction. When you terminate active employment you may be eligible to continue your coverage under COBRA. Please see the Continuation of Coverage section for more information on COBRA coverage.

When you terminate coverage as a retiree your coverage continues in effect through the end of the month of your last monthly deduction.

It is your responsibility to verify your benefit deductions on your check or retirement stub as well as your Summary Statement of Benefits to make sure they match the coverage you requested. Contact your Agency Benefits coordinator (for active employees) or the Employee Benefits Division (for retirees) immediately if there is an error or omission in your deductions.

Payroll Deductions and Effective Dates of Coverage for Active Employees

The effective dates of coverage for active employees depend upon the pay period ending dates for which a deduction is taken from each paycheck. The pay period ending date is shown on the check stub of each paycheck. Paychecks are distributed to employees approximately one week after the pay period ending date.

If you miss deductions for two pay periods because of an unpaid absence you must pay all missed premiums including the State subsidy (if applicable) or your coverage will be cancelled for the remainder of the enrollment year. Missing one or two pay periods is considered a Short Term Leave of Absence. Please review the policy in Continuation of Coverage section of this booklet. The Employee Benefits Division will bill you for missed premiums and deductions. The payment deadline is strictly enforced. If you missed deductions because you transferred between two agencies please contact your Agency Benefits Coordinator immediately so that your Coordinator can calculate your share of the premiums and submit a Retroactive Adjustment Form. This must be done so that your benefits are not cancelled.

Changes in Coverage

Enrollment in any State health plan or changes in coverage should only occur during the designated Open Enrollment period each year. Once you have selected a plan, you must stay in the plan, at the selected coverage level for the full plan year, unless there has been a qualifying event. The plan year runs from July 1 to June 30.

Qualifying events include a change in status, such as a birth of a child, loss of a dependent, marriage, divorce, moving to an "out of network area", or loss of other coverage. Gaining eligibility for Medicare is a qualifying event for retirees. A qualifying event can also occur if your spouse's employment is terminated and you or your dependents lose coverage as a result.

You have 60 days from the qualifying event to make changes to your benefits. Any changes submitted after 60 days of the qualifying event will not be processed. You will have to wait until the next Open Enrollment to make a change. An Enrollment Worksheet must be completed. Contact your Agency Benefits Coordinator (active employees) or the Employee Benefits Division (for retirees).

Mistakes in completing the Enrollment Worksheet, using the Interactive Voice System (IVR) and dependent enrollment system, and other errors made by the employee do not constitute an administrative (State) error. Refunds are only approved for an administrative (State) error. Please make your IVR selections carefully and review your Enrollment Worksheet before submitting.

If you discover an error on your worksheet or Summary Statement of Benefits please contact your Agency Benefits Coordinator or the Employee Benefits Division immediately. If you fail to contact your Agency Benefits Coordinator or Employee Benefits Division within 30 days of receiving your Summary Statement or submitting your Enrollment Worksheet you will have to wait until the next Open Enrollment period before your error can be corrected.

Removing Your Divorced Spouse

You must file an Enrollment Worksheet to remove your ex-spouse as soon as you are divorced. The ex-spouse cannot be continued on the employee's/retiree's State benefits coverage. If you fail to remove your ex-spouse within 60 days of your divorce you will be required to pay the insurance premium plus the State subsidy from the date of the divorce. You may also face disciplinary action, termination of employment and/or criminal prosecution.

If an employee or retiree is obligated through terms of the divorce to provide health insurance coverage for the ex-spouse, that coverage can be provided for a limited time under COBRA and Maryland law. If COBRA is selected the ex-spouse will have his/her own account and will be responsible for paying premiums directly. COBRA coverage is not subsidized by the State. Please see the Continuation of Coverage section of this book for more information.

Refunds

A refund request for any reason other than an administrative error by a State agency or the State cannot be approved. Examples of refund requests that will be denied include:

- An incorrect coverage level due to:
  - dependent no longer eligible
  - death of a spouse
  - divorce
  - change in Medicare status
- Incorrect benefits due to error in the Enrollment Worksheet or incorrect use of the IVR during the Open Enrollment period
- Incorrect deductions for changes that were not made within 60 days of the qualifying event

CONTINUATION OF COVERAGE

While on a Leave of Absence

If you take a leave of absence without pay (LAWP) you may continue the same health benefits coverage by electing to enroll and paying 100% of the premiums.

If you take a leave of absence pursuant to the Family Medical Leave Act (FMLA), special rules govern the continuation of your health benefits. Contact your Agency Benefits Coordinator.

Short Term LAWP: If you are on short term LAWP (two pay periods or less for employees who are paid bi-weekly), and it is not FMLA leave or due to a job-related accident or injury, you must pay 100% of all missed premiums in order to continue your benefits. You will receive a bill from the Employee Benefits Division for your missed premiums. Deductions may resume if you return to work prior to the due date on the bill. However, payment for the missed premiums is still due. If you do not pay by the due date on the "no-pay" bill, your enrollment and benefits coverage will be cancelled for the balance of the plan year.

If your short term LAWP is due to a job-related accident or injury, or an approved FMLA leave, you are entitled to the full State subsidy and are responsible for the employee's share of the premium only. When you receive your bill, please contact your Agency Benefits Coordinator, who will complete a retroactive adjustment form and collect your portion of the premiums. You must make up missed premiums within the requested time frame or your enrollment and benefits coverage will be cancelled. There will be a break in your coverage until you return to work and request re-enrollment in health benefits. Payment deadlines are strictly enforced.

Long Term LAWP: If you are on a leave of absence without pay for more than two bi-weekly pay periods, your leave is considered a long-term LAWP. If you are on an approved long-term LAWP, you may elect to continue or discontinue health insurance for the duration of the LAWP, up to a maximum of two years.

If you wish to continue, you must complete a COBRA/LAWP Enrollment Worksheet and submit it to your Agency Benefits Coordinator. This Worksheet should be completed as soon as you know you will miss two pay periods or more. The Worksheet will not be accepted any later than 60 days after the effective date of the LAWP.

You may continue any or all of your current health benefit plans, or you may reduce your coverage level when enrolling for LAWP benefits. Otherwise, you are subject to the same limitations in changing coverage as an active employee.

Once enrolled in coverage while on LAWP, you are responsible for 100% of the premium unless the LAWP is due to a job-related accident or injury or an approved FMLA leave. If you are entitled to the State subsidy, your Agency Benefits Coordinator must have the Agency Fiscal Officer complete the applicable section of the COBRA/LAWP Enrollment Worksheet. The Employee Benefits Division will bill you for the appropriate amount due.

Coupons and Payments: All State employees who are on a Leave of Absence without Pay will be mailed payment coupons, which must be included with their premium payments at the address given on the enrollment worksheet. Your benefits will be effective as of the date noted on your letter but no claims will be paid until the Employee Benefits Division receives your payment. Payments are due the first of every month with a 30-day grace period. All benefits are inactive until payment is received for each month. Payment may be made in advance to cover any or all coupon(s) received, but must be made in full monthly increments. If payment is not received by the end of the 30-day grace period, the employee's coverage will be cancelled. There will be a break in your coverage until you return to work and request re-enrollment in health benefits. Payment deadlines are strictly enforced. If you do not receive these coupons within one month of signing your Enrollment Worksheet or if you change your mailing address, please contact your Agency Benefits Coordinator or the Employee Benefits Division immediately.

Continuation of Coverage After Employment Ends

You and/or your dependents may elect to continue the Health, Prescription Drug, Dental and Health Care Spending Account, using post-tax premium payments, for a time frame determined in accordance with the regulations.

If you or one of your dependents experiences a qualifying event (see COBRA chart on next page), you or your dependent may be eligible to continue the same health benefits that you or your dependents were enrolled under at the time of the qualifying event.

If coverage is continued under these provisions, you and/or your dependents will be responsible for paying 100% of the premiums, plus an additional 2% of the premium to defray administrative costs. If payment is not received by the end of the grace period, your benefits will be terminated. If your enrollment is cancelled because you did not make the required payment, you will not have the opportunity to enroll again.

Coupons and Payments: All COBRA enrollees will be mailed payment coupons, which must be included with their premium payments at the address given on the enrollment worksheet. Your COBRA benefits will be effective as of the date noted on your letter but no claims will be paid until the Employee Benefits Division receives your payment. Payments are due the first of every month with a 30-day grace period. All benefits are inactive until payment is received for each month. Payment may be made in advance to cover any or all coupon(s) received, but must be made in full monthly increments. If payment is not received by the end of the 30-day grace period, your COBRA coverage will be cancelled and you will not be permitted to re-enroll. Payment deadlines are strictly enforced. If you do not receive these coupons within one month of signing your Enrollment Worksheet or you change your mailing address, please contact your Agency Benefits Coordinator or the Employee Benefits Division immediately.

COBRA (CONTINUATION OF COVERAGE) CONDITIONS

Qualifying Event	Person Affected	Length of Continuation of Coverage
Termination of employment (other than for gross misconduct), including layoff or resignation of employee	Employee Spouse Dependent Child(ren)	18 Months or until eligible for coverage elsewhere, including Medicare [1], whichever occurs first.
Dependent child(ren) of an employee or retiree no longer meets the dependent eligibility requirements	Child (ren)	36 Months or until eligible for coverage elsewhere, including Medicare [1], whichever occurs first.
Death of employee or retiree	Spouse Dependent Child(ren)	36 Months or until eligible for coverage elsewhere, including Medicare [1], whichever occurs first.
Divorce or legal separation from employee or retiree	Former Spouse Legally separated Spouse	Indefinitely or until eligible for coverage elsewhere, including Medicare or remarriage, whichever occurs first. COBRA coverage includes the ability to enroll with dependents who meet the eligibility criteria.
	Step Child(ren) of employee or retiree	If enrolled separately, 36 months or until eligible for coverage elsewhere, including Medicare[1], whichever occurs first.
Qualifying Events after the Start of COBRA (Second COBRA Qualifying Events)		
Divorce or legal separation from COBRA participant	Legally Separated Spouse Step Child(ren) of participant	36 months from the original qualifying event or until eligible for coverage elsewhere, including Medicare[1], whichever occurs first.
Dependent child(ren) of a COBRA participant who no longer meets the dependent eligibility requirements	Child(ren)	36 months from the original qualifying event or until eligible for coverage elsewhere, including Medicare[1], whichever occurs first.
Total and Permanent Disability of the employee (as defined by the Social Security Act) with in the first 60 days of COBRA coverage	Employee Spouse Dependent Child(ren)	The 18 months can be extended to 29 months at increased premiums equal to 150% of usual premiums for the additional 11 months.

[1] If you are enrolled in Medicare Parts A & B prior to leaving State service, you are entitled to elect continued coverage at the full COBRA rate. If you become entitled to Medicare while on COBRA, you will not be able to continue your coverage after the entitled date. If you have dependents on your COBRA coverage when you become entitled to Medicare, your dependents may elect to continue their coverage on COBRA.

The following memorandum entitled "Notification of Continuation of Coverage" reviews your COBRA rights and responsibilities. If you have questions about a qualifying event or Continuation of Coverage please contact the Employee Benefits Division.

This notice on possible future group health insurance continuation coverage rights applies individually to State employees and all covered dependents**.** It is important that all covered individuals take the time to read this notice carefully and be familiar with its contents. If there is a covered dependent whose legal residence is not yours, please provide written notification with the **Address Notification Form** to the Employee Benefits Division so a notice can be sent to that covered dependent as well. In this Notice, the term "employee" also means a retiree.

You are receiving this notice because you have coverage under the State of Maryland Employee and Retiree Health and Welfare Benefits Program (the Program). The Department of Budget and Management Employee Benefits Division administers the Program. The Program sponsored by the State of Maryland is a governmental group health plan covered by the Public Health Service Act, which includes the COBRA continuation of coverage provisions described in this Notice. This Notice explains continuation coverage rights for only these health benefits offered through the Program: the medical PPO, the medical POS, the medical HMO, the prescription plan, the dental PPO, the dental POS and the Health Flexible Spending Arrangement. You may be enrolled in one or more of these benefits. This Notice does not apply to any other benefits offered by the State of Maryland or through the Program, such as the dependent care flexible spending arrangement, life insurance benefit, long term care benefit, or accidental death and dismemberment insurance benefit.

Under federal law, group health plans like the Program must offer covered employees (including retirees) and covered family members the opportunity for a temporary extension of health coverage (called COBRA continuation coverage) at group rates when coverage under the health plan would otherwise end due to certain qualifying events. This Statement is intended to inform all plan participants, in a summary fashion, of potential future options and obligations related to COBRA continuation coverage. Should an actual qualifying event occur in the future, the State of Maryland would send you additional information and the appropriate election notice at that time. **Please take special note, however, of your notification obligations that are highlighted later in this Statement.**

Who is Entitled to Elect COBRA Continuation Coverage?

Qualified beneficiaries are entitled to elect COBRA coverage. Qualified beneficiaries are the employee, the spouse and the dependent children who lost group health coverage as a result of a qualifying event.

What are Qualifying Events and how will I know the COBRA coverage is available?

When the qualifying event is the end of employment, reduction of employment hours or death of the employee, the Program will offer COBRA coverage to qualified beneficiaries. You will not need to notify the Employee Benefits Division of these three qualifying events because your employing agency should notify the Employee Benefits Division of those events. You will need to notify the Employee Benefits Division of any other qualifying event.

Qualifying Events For Covered Employee: If you are the covered employee, you may have the right to elect this health plan continuation coverage **if** you lose your group health coverage because of the following qualifying events: termination of your employment (for reasons other than gross misconduct on your part), reduction in your hours of employment, or a reduction in your hours of employment. Remember, the term "covered employee" includes covered retirees in the Program.

Qualifying Events For Covered Spouse: If you are the covered spouse of an employee, you may have the right to elect this health plan continuation coverage for yourself **if** you lose group health coverage under the Program because of any of the following qualifying events:

1. A termination of your spouse's employment (for reasons other than gross misconduct);
2. A reduction in your spouse's hours of employment;
3. The death of your spouse;
4. Divorce from your spouse. If your spouse (the employee or retiree) reduces or eliminates your group health coverage in anticipation of your divorce or legal separation, and a divorce subsequently occurs, then the divorce may be considered a qualifying event for you even though you lost coverage earlier than the date of the divorce. You must prove the loss of coverage was in anticipation of the divorce.

Qualifying Events For Covered Dependent Children: If you are the covered dependent child of an employee, you may have the right to elect continuation coverage for yourself **if** you lose group health coverage under the Program because of any of the following qualifying events:

1. A termination of the employee's employment (for reasons other than gross misconduct);
2 A reduction in the employee's hours of employment;
3. The death of the employee;
4. Parent's divorce or, if applicable, legal separation;
5. You cease to be a "dependent child" under the terms of the Program. For example, if you lose coverage because you are over the age of 19 and are not a full-time student.

If a covered employee qualified beneficiary has or adopts a child during a period of COBRA continuation coverage, the new child may be eligible for COBRA continuation coverage that runs for the same period as the covered employee qualified beneficiary's coverage. The child must meet the eligibility requirements of the Program. In the case of a newborn or adopted child that is added to a covered employee qualified beneficiary's COBRA coverage, then the first 60 days of continuation coverage for the new born or adopted child is measured from the date of the birth or the date of the adoption.

When is COBRA continuation coverage available?

COBRA continuation coverage starts from the day you lose coverage due to a qualifying event – the end of the payroll deduction period in which the qualifying event occurred.

Important: Notifications Required By the Employee, Retiree, Spouse, and Dependent

For qualifying events when the Program will not provide notice to you (i.e. divorce and a covered dependent ceasing to meet the definition of a "dependent" under the Program's rules), you must notify the Employee Benefits Division **within 60 days** of the later of these two dates: (1) the date of the event or (2) the date on which health plan coverage would be lost under the terms of the Program because of the event qualifying event. If you do not notify the Employee Benefits Division of the qualifying event within 60 days, you will lose the right to elect COBRA coverage. Under federal law, this is your responsibility.

To provide the required notification, you must contact the Employee Benefits Division and request that a COBRA worksheet be mailed to you. You must then fill out the worksheet, attach documentation of the qualifying event (e.g. copy of divorce decree), and mail everything to: Employee Benefits Division, ATTN: COBRA Unit, 301 West Preston Street, Room 510, Baltimore, Maryland 21201.

If this Statement is not completed according to these procedures and within the required 60-day notification period, then rights to continuation coverage will be forfeited. Carefully read the dependent eligibility rules contained in this booklet so all covered members are familiar with when a dependent ceases to be a dependent under the terms of the plan.

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage; parents may elect COBRA coverage on behalf of minor children who were covered dependents. The Employee Benefits Division will send to you an Election Notice outlining your rights to COBRA continuation coverage after it receives notification of a qualifying event from you or the employee's agency.

Each qualified beneficiary has 60 days from the date of the Election Notice (or the date the health plan coverage was lost if later) to elect COBRA continuation coverage. This is the maximum period allowed to elect continuation coverage, as the plan does not provide an extension of the election period beyond what is required by law. If a qualified beneficiary does not elect continuation coverage within this election period, then rights to continue health insurance will end and the individual will cease to be a qualified beneficiary.

Each qualified beneficiary has the right to elect COBRA continuation coverage in the group health benefits the qualified beneficiary had on the last day of coverage in the Program. For example, if the qualified beneficiary is enrolled in a medical POS plan and the prescription plan but not a dental plan on the last day of coverage before the qualifying event, the qualified beneficiary may elect to continue coverage in that medical POS plan and in the prescription plan but may not add coverage under a dental plan during the COBRA Election Period.

If a qualified beneficiary elects continuation coverage, the qualified beneficiary will be required to pay the entire cost for the health insurance, plus a 2% administration fee. COBRA continuation coverage is required to be identical to the coverage provided under the plan to similarly situated non-COBRA participants and/or covered dependents. Should coverage change or be modified for non- COBRA participants, then the change and/or modification will be made to your COBRA coverage as well.

How long does COBRA continuation coverage last?

COBRA coverage is a *temporary* continuation of coverage. Depending on the nature of the qualifying event that caused the loss of coverage, COBRA coverage may last a **maximum** of 18 months or 36 months, except in the case of COBRA continuation coverage in a health flexible spending arrangement. ***If you are participating in a health flexible spending account at the time of the qualifying event, you will only be allowed to continue the health flexible spending account until the end of the current plan year in which the qualifying event occurs.*** If you choose to continue your Health Care Spending Account on COBRA, you will pay 102% of the full premium through post-tax payments. See below for a description of how COBRA continuation coverage may end earlier than these maximum periods.

Length Of Continuation Coverage - 18 Months: If the event causing the loss of coverage is a termination of employment (other than for reasons of gross misconduct) or a reduction in work hours, then each qualified beneficiary will have the opportunity to continue coverage for 18 months from the date of the qualifying event. This 18-month coverage may be extended in only limited situations: (1) a Social Security disability determination, (2) when a second qualifying event occurs during COBRA continuation coverage, and (3) when the employee had become eligible for Medicare within 18 months before the termination of employment or reduction in hours (see below for explanation). You must notify the Employee Benefits Division in writing within 60 days of either of these events in order to be

eligible for an extension of the maximum COBRA coverage period. Failure to do will jeopardize your ability to have an extension.

Social Security Disability: The 18 months of continuation coverage can be extended for an additional 11 months of coverage, to a maximum of 29 months, for all qualified beneficiaries if the Social Security Administration determines a qualified beneficiary was disabled according to Title II or XVI of the Social Security Act on the date of the qualifying event or at any time during the first 60 days of continuation coverage. The disability must last during the entire 18 months of COBRA coverage. It is the qualified beneficiary's responsibility to obtain this disability determination from the Social Security Administration and provide a copy of the determination to the Employee Benefits Division within 60 days after the later of: the date of the determination, the date of the termination of employment of reduction in hours, or the date the original 18-month coverage period expires. This notice must be provided no later than the date the original 18-month coverage period expires. If you do not notify the Employee Benefit Division in writing within the time frame, you may lose the ability to extend COBRA coverage.

This extension applies separately to each qualified beneficiary. If the disabled qualified beneficiary chooses not to continue coverage, all other qualified beneficiaries are still eligible for the extension. If coverage is extended, and the disabled qualified beneficiary has elected the extension, then the applicable premium rate is 150% of the premium rate. If only the non-disabled qualified beneficiaries extend coverage, the premium rate will remain at the 102% level. It is also the qualified beneficiary's responsibility to notify the Employee Benefits Division within 30 days if a final determination has been made that they are no longer disabled.

Secondary Qualifying Events: Another extension of the 18 or above mentioned 29-month continuation period could occur, if during the 18 or 29 months of COBRA continuation coverage, a second event takes place (divorce, legal separation, death, or a dependent child ceasing to be a dependent) that would have caused the qualifying beneficiary to loss coverage under the Program if the first qualifying event (termination of employment of reduction of hours) had not occurred. If a second event occurs, then the original 18 or 29 months of continuation coverage can be extended to 36 months from the date of the original qualifying event date for eligible dependent qualified beneficiaries. If a second event occurs, it is the qualified beneficiary's responsibility to notify the Employee Benefits Division in writing within 60 days of the second event and within the original 18 or 29 month continuation period. In no event, however, will continuation coverage last beyond 36 months from the date of the first qualifying event that originally made the qualified beneficiary eligible for COBRA continuation coverage. A reduction in hours followed by a termination of employment is not a qualifying second event.

Length Of Continuation Coverage - 36 Months: If the original event causing the loss of coverage was the death of the employee or a dependent child ceasing to be a dependent child, then each qualified beneficiary will have the opportunity to continue coverage for 36 months from the date of the qualifying event. When the employee had become entitled to Medicare benefits less than 18 months before the termination of employment or reduction in work hours, the covered spouse and covered dependent qualifying beneficiaries may be entitled to COBRA coverage for up to 36 months. This extension does not apply to the employee, who will only have a maximum of 18 months of COBRA coverage unless a special extension as the result of a secondary qualifying event occurs. The 36-month coverage period cannot be extended.

Length of Continuation Coverage – Indefinitely: If the original event causing the loss of group health coverage was a divorce from the employee, Maryland State law gives the qualified beneficiary the opportunity to continue coverage indefinitely, until Program coverage for the employee terminates, the qualified beneficiary obtains coverage elsewhere (including Medicare), or the qualified beneficiary remarries. This indefinite period of continuation coverage is a result of a Maryland state law that is similar to COBRA and does not apply to health flexible spending arrangements. However, the dependent child qualified beneficiary will also lose coverage when the child does not meet Program eligibility requirements and former stepchildren of the covered employee do not gain access to indefinite continuation coverage under these provisions of Maryland law.

Eligibility, Premiums, And Potential Conversion Rights: A qualified beneficiary does not have to show they are insurable to elect continuation coverage, however, they must have been actually covered by the plan on the day before the event to be eligible for continuation coverage. An exception to this rule is if while on continuation coverage a baby is born to or adopted by a covered employee qualified beneficiary. If this occurs, the new born or adopted child can be added to the plan and will gain the rights of all other qualified beneficiaries. The COBRA timeline for the new born or adopted child is measured from the date of the original qualifying event. Procedures and timelines for adding these individuals can be found in your benefits booklets and must be followed. The plan administrator reserves the right to verify continuation eligibility status and terminate continuation coverage retroactively if a qualified beneficiary is determined to be ineligible or if there has been a material misrepresentation of the facts.

A qualified beneficiary will have to pay all of the applicable premium plus a 2% administration charge for continuation coverage. These premiums will be adjusted during the continuation period if the applicable premium amount changes. In addition, if continuation coverage is extended from 18 months to 29 months due to a Social Security disability, (Name of Employer) can charge up to 150% of the applicable premium during the extended coverage period. Qualified beneficiaries will be

allowed to pay on a monthly basis. In addition there will be a maximum grace period of (30) days for the regularly scheduled monthly premiums. At the end of the 18, 29, or 36 months of continuation coverage, a qualified beneficiary will be allowed to enroll in an individual conversion health plan provided under if an individual conversion plan is available at that time.

Termination Of Continuation Coverage: The time frames described above are only potential maximum periods for COBRA continuation coverage. COBRA coverage can end before those periods finish. The law provides that *if elected and paid for* your continuation coverage will end prior to the maximum continuation period for any of the following reasons:

1. State of Maryland ceases to provide any group health plan to any of its employees;
2. Any required premium for continuation coverage is not paid in a timely manner;
3. A qualified beneficiary first becomes, after the date of COBRA election, covered under another group health Plan that does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary other than such an exclusion or limitation which does not apply to or is satisfied by such beneficiary by reason of the Health Insurance Portability and Accountability Act;
4. A qualified beneficiary first becomes, after the date of COBRA election, entitled to Medicare;
5. A qualified beneficiary extended continuation coverage to 29 months due to a Social Security disability and a final determination has been made that the qualified beneficiary is no longer disabled;
6. A qualified beneficiary notifies the State of Maryland, Employee Benefits Division they wish to cancel continuation coverage;
7. For cause, on the same basis that the plan terminates the coverage of similarly situated non-COBRA participants.

Is COBRA continuation coverage for my Health Flexible Spending Arrangement (FSA) Different?

Yes. COBRA continuation coverage for the Health FSA will be offered only to qualified beneficiaries losing coverage through the end of the plan year in which the qualifying event occurs. This coverage cannot be extended beyond the end of the plan year, regardless of the qualifying event or whether a second qualifying event occurs. The use it or lose it rule will still apply so any unused amounts will be forfeited at the end of the plan year and COBRA coverage will terminate at the end of the plan year. You must pay a premium for continued Health FSA coverage that includes a 2% administrative charge for the coverage. Unless otherwise elected, all qualified beneficiaries who were coverage under the Health FSA will be covered together for Health FSA COBRA coverage. However, each qualified beneficiary could elect to exercise Health FSA COBRA election rights individual to cover the qualified beneficiary only, with a separate Health Care FSA limit and a separate premium. Please note that all Health FSA premiums are paid with post-tax dollars.

Notification Of Address Change: To insure all covered individuals receive information properly and efficiently, *you are required to* notify the State of Maryland, Employee Benefits Division of any address change as soon as possible. A Change of Address Notification form is available on-line at www.dbm.maryland.gov, Employee Benefits link. Instructions for completing and filing the form are at the bottom of the form and must be followed. Failure on your part to do so will result in delayed notifications or a loss of continuation coverage options.

How do I notify to the Employee Benefit Division in case that this Notice advises I must provide notification to protect my rights?

In every instance that you must provide notice to the Employee Benefits Division in order to protect your rights, whether the notice is of a first or second qualifying event, Social Security disability, or the addition of a new qualified beneficiary, you must provide written notice to the Employee Benefits Division at the address below. You may be asked to complete a form and provide additional documentation. Failure to provide a required notice to the Employee Benefits Division within the required time period may cause you to lose COBRA rights.

Any Questions?

Remember, except for notifying you of your responsibilities to notify the Employee Benefits Division of a divorce or a dependent child ceasing to meet Program eligibility requirements, this notice is simply a summary of your potential future options. Should an actual qualifying event occur and it is determined that you are eligible for continuation, you will be notified of all your actual rights at that time as part of the COBRA Election Notice. If any covered individual does not understand any part of this summary notice or has questions regarding the information or your obligations, please contact the State of Maryland, Employee Benefits Division at (410) 767-4775, press Option 2.

The Program name and address is: The State of Maryland Employee and Retiree Health and Welfare Benefits Program, c/o Department of Budget and Management Employee Benefits Division, Room 510, 301 West Preston Street, Baltimore, Maryland 21201.

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT)

Certificates of Coverage and the Health Insurance Portability and Accountability Act of 1996 (HIPAA):
A federal law, HIPAA, requires employers to provide certificates of coverage to all former employees, who then can give the certificates to their new employers. If you or your dependents obtain new employment, you may request a certificate of coverage from the State, which describes the length and types of coverage (i.e., medical, dental, etc.) you and your dependents had under the State program. You may request a HIPAA Certificate of coverage by writing to the Department of Budget and Management (DBM), Employee Benefits Division, at the address on the back cover of this booklet.

Notice of Privacy Practices and HIPAA Authorization Form:
The State conforms to the federal HIPAA regulations and State regulations on the privacy of your health information. Please read the "Notice of Privacy Practices" below, which describes the privacy practices of the State Employees Health Benefits Program.

HIPAA and State regulations require your written authorization to disclose certain health information to plans and regulatory agencies. If your written authorization is needed, you may use the "HIPAA Authorization Form" to provide the needed authorization that is located on our website, www.dbm.maryland.gov.

NOTICE OF PRIVACY PRACTICES
STATE EMPLOYEES AND RETIREEES HEALTH BENEFITS PROGRAM

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Under federal and State law, DBM administers the State Employees and Retirees Health Benefits Program (the Program), protects the privacy of your protected health information. DBM takes steps to ensure that your protected health information is kept secure and confidential and is used only when necessary to administer the Program. DBM is required to give you this notice to tell you how DBM may use and give out ("disclose") your protected health information held by DBM. This information generally comes to DBM from you when you enroll in a health plan and from your health plan in the administration of the Program.

Your health plan in the Program (for example, the CareFirst BlueCross BlueShield PPO or the Optimum Choice HMO) will also protect, use, and disclose your personal health information. For questions about your health information held by your health plan, please contact your health plan directly. The plans in the Program all follow the same general rules that DBM follows to protect, use and disclose your protected health information. Each plan will use and disclose your protected health information for payment purposes, for treatment purposes and for administration purposes.

DBM has the right to use and disclose your protected health information to administer the Program. For example, DBM will use and disclose your protected health information:

- To communicate with your Program health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue. DBM may need a written authorization from you for your health plan to discuss your case.
- To determine your eligibility for benefits and to administer your enrollment in your chosen health plan.
- For payment related purposes, such as to pay claims for services provided to you by doctors, hospitals, pharmacies and others for services delivered to you that are covered by your health plan, to coordinate your benefits with other benefit plans (including workers' compensation plans or Medicare), or to make premium payments.
- For treatment related purposes, such as to review, make a decision about, or litigate any disputed or denied claims.
- For health care operations, such as to conduct audits of your health plan's quality and claims payments and to procure health benefits plan offered through this Program, without use of individual identifiable information.

DBM will also use and give out your protected health information:

- To you or someone who has the legal right to act for you (your personal representative). To authorize someone other than you to discuss your protected health information with DBM, please contact DBM to complete an authorization form.
- To law enforcement officials when investigating and/or processing alleged or on-going civil or criminal actions.
- Where required by law, such as to the Secretary of the U.S Department of Health and Human Services, to the Office of Legislative Audits, or in response to a subpoena.
- For healthcare oversight activities (such as fraud and abuse investigations).
- To avoid a serious and imminent threat to health or safety.

By law, DBM must have your written permission (an "authorization") to use or give out your protected health information to other persons or organization as already described in the notice. You may revoke your written permission at any time, except if DBM has already acted based on your permission.

By law, you have the right to:

- Make a written request and see or get a copy of your protected health information held by DBM or a plan in the Program.
- Amend any of your protected health information created by DBM if you believe that it is wrong or if information is missing, and DBM agrees. If DBM disagrees, you may have a statement of your disagreement added to your protected health information.
- Ask DBM in writing for a listing of those getting your protected health information from DBM for up to 6 years prior to your request. The listing will not cover your protected health information that was used or disclosed for treatment, health care operations or payment purposes, given to you or your personal representative, disclosed pursuant to an authorization, or was disclosed prior to April 14, 2003.
- Ask DBM in writing to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address) if using your address on file creates a danger to you.
- Ask DBM in writing to limit how your protected health information is used or given out. However, DBM may not be able to agree to your request if the information is used for treatment, payment or to conduct operations in the manner described above or if a disclosure is required by law.
- Get a separate paper copy of this notice.

If you wish to exercise any of these rights in connection with the Program or a health plan in the Program, you may contact DBM at the address below. You may also contact your dental plan, medical PPO, medical POS or medical HMO plan directly.

For more information on exercising your rights set out in this notice, visit at the DBM website: www.dbm.maryland.gov. You may also call 410-767-4775 and ask for DBM's Program privacy official for this purpose. If you believe DBM has violated your privacy rights set out in this notice, you may file a written complaint with DBM at the following address:

Department of Budget and Management
Employee Benefits Division
301 West Preston Street, Room 510
Baltimore, MD 21201
ATTN: HIPAA Privacy Officer

Filing a complaint will not affect your benefits under the Program. You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services at:

Department of Health and Human Services
Office of Civil Rights
150 South Independence Mall West, Suite 372
Public Ledger Building
Philadelphia, PA 19106-9111

MEDICARE COORDINATION OF BENEFITS (COB)

Active employees and their covered dependents do not have to sign up for Medicare when they become eligible because of age or disability, but instead, keep using the State health benefits as their only coverage. **However, retirees, the dependents of retirees, and everyone who becomes eligible for Medicare due to End Stage Renal Disease MUST enroll in both Medicare Parts A & B as soon as they are eligible (due to age or disability) in order to have full claims coverage.** When you are a retiree or a dependent of a retiree and you are eligible for Medicare Parts A & B, Medicare Parts A & B become your primary insurance and the State health plan becomes a supplemental policy to Medicare. Medicare Part A helps pay for hospital care, some skilled nursing facility care, and hospice care; Medicare Part B helps pay for physician charges and other medical services.

If you are an employee, retiree or a dependent who has Medicare entitlement because of End Stage Renal Disease (ESRD), see the ESRD rules on this page.

Retirees and/or their dependents enrolled in the State Health Benefits Program must enroll in both Parts A & B as soon as they are eligible, either due to age or disability. The State plan will cover only that portion of hospital and medical bills not covered by Medicare. **If you and/or your covered dependents are eligible for, but not enrolled in both Parts A & B, you will become responsible for the claims costs that Medicare would have paid**.

Age: For most individuals who are not disabled, Medicare eligibility begins on the first day of the month in which they reach age 65. However, if you were born on the first day of a month, your Medicare eligibility begins on the first day of the month prior to the month in which you reach age 65. In order to have full coverage, retirees and their covered dependents must enroll in Parts A & B at age 65, regardless of what the Social Security Administration determines to be your "full retirement age".

Disability: Persons who are certified as being disabled by the Social Security Administration become eligible for Medicare two years (24 months) after their disability determination date. If Social Security denies Medicare coverage, you must provide a copy of the Social Security's denial to the Employee Benefits Division. If your Medicare entitlement is due to disability and the Social Security Administration determines that your disability status ends, please provide the Employee Benefits Division documentation from the Social Security Administration stating when Medicare entitlement ended.

End Stage Renal Disease (ESRD): If your Medicare eligibility is due to ESRD, you must sign up for both Medicare Parts A & B as soon as you are eligible. The Social Security Administration has determined that individuals who have permanent kidney failure (ESRD), regardless of their age, can receive services through Medicare. If you or your covered dependents are entitled to Medicare due to ESRD, contact your local Social Security Office to request the Medicare handbook.

The Centers for Medicare and Medicaid Services (CMS) determined that when Medicare is due to ESRD, whether you are an active employee or a retiree, your State health plan will remain your primary insurer for the first 30 months. At the end of the 30-month COB period, Medicare becomes the primary insurer. Before your 30-month COB period ends, you should contact the Employee Benefits Division to complete an enrollment form, changing your State health plan to a supplemental policy to Medicare.

If you are no longer eligible for Medicare Parts A & B for ESRD, please contact your local Social Security Office and request a cancellation of both Medicare Parts A & B. After you receive your cancellation letter from the Social Security Administration, please complete an Enrollment Worksheet to change your coverage level and submit it to the Employee Benefits Division at the address on the back cover of this book with a copy of the notice of cancellation of your Medicare coverage.

Questions about Medicare COB

If you have questions about your coverage level in the State Retirees Health Benefits Program, or if you have questions about claims payments and how your plan coordinates with Medicare, contact the Employee Benefits Division at the phone number on the back cover of this booklet.

SUMMARY OF CHANGES YOU MAY SEE ONCE YOU ENROLL IN MEDICARE IF YOUR PROVIDER PARTICIPATES WITH YOUR HEALTH PLAN AND MEDICARE:

State Plan	Eligible for Medicare	How do Benefits Change?
Preferred Provider Organization (PPO)	Medicare becomes the primary coverage. All claims go to Medicare first. PPO pays that portion of the Medicare allowed amount that Medicare does not pay, including any Medicare deductibles.	• Out-of-pocket costs are reduced. • Out-of-network deductible is waived. • Out-of-pocket costs occur only if your provider does not participate with Medicare.
Point-of-Service Plan (POS)	For in-network services, the POS contracts with Medicare to recover a portion of the costs of treatment. For out-of-network services, Medicare becomes the primary coverage. All claims are filed with Medicare first.	• In-network, co-pays remain the same. • Out-of-network, you must pay the $100 Medicare Part B deductible, but it also counts as part of your POS out-of-network deductible ($250/individual; $500/family).
Health Maintenance Organization (HMO)	The HMO contracts with Medicare to recover a portion of the costs of treatment.	• No change. Co-pays are the same as before and you must continue to use providers in the HMO network in order to receive the HMO benefit.

BENEFITS APPEAL PROCESS

The Department of Budget and Management strives to ensure proper coverage and claims payments under the benefits program. If you believe that your plan has denied payment of a covered benefit to which you are entitled, you should contact the plan first. The plan will explain its internal appeal process and inform you of the steps you must take to file an appeal to the plan. HMO members may also file an appeal to the Maryland Insurance Administration (MIA).

Once you have exhausted all of the plan's appeals processes and if you are not satisfied with the plan's decision following its review of your appeal, you may submit a written request for review by the State Benefits Review Committee of the Department of Budget and Management. The State Benefits Review Committee reviews appeals by members and providers on denied benefits and/or disputed claims payments. This request must be submitted in writing within 30 days of your receipt of the plan's decision, and should describe the nature of your claim and the reasons why you believe that the claim has been improperly denied. The address of the Benefits Review Committee is: Benefits Review Committee, Department of Budget and Management, 301 West Preston Street, Room 510, Baltimore, Maryland, 21201, or fax to 410-333-7122.

JULY 2005 – JUNE 2006
STATE OF MARYLAND RETIREE PREMIUM RATE TABLE

Medical Premiums without Medicare					Medical Premiums with Medicare						
Medical Plans	**Retiree Only**	**Retiree & Child**	**Retiree & Spouse**	**Retiree & 2 or More**	**Retiree Only with Medicare**	**Retiree + 1, 1 with Medicare**	**Retiree + 1, Both with Medicare**	**Retiree +2, 1 with Medicare**	**Retiree + 2, 2 with Medicare**	**Retiree + 2 or more All with Medicare**	**Retiree + 3 or more, 1, 2, or 3 with Medicare**
CareFirst Blue Cross Blue Shield (CFBCBS) PPO	$82.68	$148.83	$148.83	$206.71	$41.35	$124.01	$82.68	$190.16	$165.36	$124.01	$206.71
MLH-Eagle PPO	$72.20	$129.97	$129.97	$180.52	$36.11	$108.30	$72.20	$166.06	$144.41	$108.30	$180.52
Aetna Quality QPOS	$48.79	$87.82	$87.82	$121.97	$24.39	$73.17	$48.79	$112.21	$97.57	$73.17	$121.97
CFBCBS-Maryland POS	$53.25	$95.85	$95.85	$133.13	$26.62	$79.88	$53.25	$122.48	$106.50	$79.88	$133.13
M.D.IPA Preferred POS	$52.09	$93.75	$93.75	$130.22	$26.04	$78.13	$52.09	$119.80	$104.17	$78.13	$130.22
CFBCBS Blue Choice HMO	$42.69	$89.59	$89.59	$110.99	$21.05	$63.39	$46.24	$105.74	$67.44	$57.84	$105.24
Kaiser HMO	$39.72	$79.44	$79.44	$99.49	$25.14	$64.86	$50.28	$99.50	$90.00	$75.42	$99.50
Optimum Choice HMO	$43.47	$90.42	$90.42	$107.81	$28.71	$72.18	$57.42	$107.81	$98.57	$86.13	$107.81

These rates are based on 16 years of Credible State service. The amount the State subsidizes varies by years or creditable service. Therefore, the amount of money deducted from your retirement check may be more than what is shown on this page. The premiums for Retirees of the Optional Retirement Program (ORP) may also vary from these rates. The Term Life Insurance premiums for July 2005 – June 2006 are located in the inside front cover of this book.

JULY 2005 – JUNE 2006
STATE OF MARYLAND PREMIUM RATE TABLE

	Biweekly Medical Premiums			Monthly Medical Premiums		
	1 Person	**2 People**	**3+ People**	**1 Person**	**2 People**	**3+ People**
CareFirst BlueCross Blue Shield (CFBCBS) PPO	$41.34	$74.42	$103.36	$82.68	$148.83	$206.71
MLH-Eagle PPO	$36.10	$64.99	$90.26	$72.20	$129.97	$180.52
Aetna Quality POS	$24.40	$43.91	$60.99	$48.79	$87.82	$121.97
CFBCBS - Maryland POS	$26.63	$47.93	$66.57	$53.25	$95.85	$133.13
M.D.IPA Preferred POS	$26.05	$46.88	$65.11	$52.09	$93.75	$130.22
CFBCBS Blue Choice HMO	$21.35	$44.80	$55.50	$42.69	$89.59	$110.99
Kaiser Permanente HMO	$19.86	$39.72	$49.75	$39.72	$79.44	$99.49
Optimum Choice HMO	$21.74	$45.21	$53.91	$43.47	$90.42	$107.81

NOTE FOR ALL RETIRED EMPLOYEES AND/OR THEIR DEPENDENTS WITH MEDICARE: SEE OPPOSITE PAGE FOR MEDICAL PLAN PREMIUM RATES WITH MEDICARE.

Prescription Plan Coverage Level	**Biweekly Prescription Premium**	**Monthly Prescription Premium**
Employee Only	$17.68	$35.36
Employee & One Child	$23.50	$47.00
Employee & Spouse	$29.35	$58.69
Employee & 2 or More	$35.36	$70.73

	Biweekly Dental Premiums			Monthly Dental Premiums		
Dental Plan Coverage Level	**Dental Benefit Providers DHMO**	**United Concordia DHMO**	**United Concordia DPPO**	**Dental Benefit Providers DHMO**	**United Concordia DHMO**	**United Concordia DPPO**
Employee Only	$3.41	$3.50	$5.37	$6.81	$6.99	$10.74
Employee & One Child	$6.81	$6.09	$10.26	$13.62	$12.18	$20.52
Employee & Spouse	$7.50	$7.00	$10.74	$14.99	$14.00	$21.47
Employee & 2 or More	$11.92	$9.84	$20.11	$23.84	$19.68	$40.22

The Term Life Insurance and AD&D premiums are located on the inside front cover of this book.

PLAN PHONE NUMBERS AND WEBSITES

Medical Plans

CareFirst BlueCross BlueShield PPO
State Operations Center
(410) 581-3601 (Baltimore)
1-800-225-0131 (Outside Baltimore)
(410) 998-7338 TTY/TDD
Open Enrollment Hotlines
(410) 581-3602 (Baltimore)
1-800-852-4463 (Outside Baltimore)
Website: www.carefirst.com/statemd

CareFirst BlueCross BlueShield Maryland POS
State Operations Center
(410) 581-0021 (Baltimore)
1-800-203-2763 (Outside Baltimore)
(410) 998-7338 TTY/TDD
Open Enrollment Hotline
(410) 581-3602 (Baltimore)
Website: www.carefirst.com/statemd

CareFirst BlueCross BlueShield BlueChoice HMO
(410) 654-8675 (Baltimore)
1-800-445-6036 (Within Maryland)
(410) 605-2492 TTY/TDD
1-800-828-3196 TTY/TDD
Website: www.carefirst.com/statemd

Kaiser Permanente (HMO)
1-800-777-7902 (Baltimore)
(443) 663-6181 (Baltimore)
(301) 468-6000 (Washington)
1-800-368-5784 (Washington)
(410) 339-5545 TTY/TDD (Baltimore)
(301) 816-6344 TTY/TDD (Washington)
Website: www.KaiserPermanente.org

Aetna QPOS
1-800-501-9837
1-800-501-9837 TTY/TDD
Website: www.aetna.com

MLH-EAGLE PPO (MAMSI)
1-800-447-6267
(301) 309-1710 TTY/TDD
Website: www.Mamsi.com

M.D.IPA Preferred POS (MAMSI)
1-800-447-6267
(301) 309-1710 TTY/TDD
Website: www.Mamsi.com

Optimum Choice HMO (MAMSI)
1-800-447-6267
(301) 309-1710 TTY/TDD
Website: www.Mamsi.com

Prescription Plan

Caremark
Prescription Drug Plan Hotline:
1-800-345-9384
Website: https://maryland.advancerx.com

Dental Plans

Dental Benefits Providers DHMO
1-877-566-3562
Website: www.dbp-inc.com

United Concordia DHMO and DPPO
1-888-MD-TEETH
(1-888-638-3384
Website: www.ucci.com

Mental Health/Substance Abuse Plan

APS Healthcare, Inc. (APS)
1-877-239-1458
Website: www.APSHelpLink.com
MD State Code: SOM2002

Long Term Care Plan

Unum Life Insurance Co.
1-800-227-4165
Website:www.unumprovident.com/enroll/maryland

Accidental Death and Dismemberment

Metropolitan Life Insurance Co.
1-888-842-2757
Website: www.metlife.com

Term Life Insurance Plan

Standard Insurance Co.
1-888-246-9002
Website: www.standard.com/mybenefits/maryland

Flexible Spending Account Administration

Refer to www.dbm.maryland.gov (click on "Employee Services") for information

Employee Benefits Division

301 West Preston Street, Room 510
Baltimore, MD 21201
(410) 767-4775
1-800-30-STATE (1-800-307-8283)
Website: www.dbm.maryland.gov
(Click on "Employee Services")
Open Enrollment Hotlines: 1-866-268-4459
Email your questions to: dbmbenefitshelp@dbm.state.md.us
(Available during Open Enrollment Only)

Call: IVR 410-669-3893 or 1-888-578-6434
TTY/TDD 410-333-5244
24 Hours a day, 7 days a week
during Open Enrollment